Supreme Court of the United States

OCTOBER TERM, 1993

MARIO M. CUOMO, ET AL.,
Petitioners,

vs.

THE TRAVELERS INSURANCE COMPANY, ET AL.,
Respondents.

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS and EMPIRE BLUE CROSS AND BLUE SHIELD,
Petitioners,

vs.

THE TRAVELERS INSURANCE COMPANY, ET AL.,
Respondents.

(For Continuation of Caption See Reverse Side of Cover)

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

APPENDIX

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HOSPITAL ASSOCIATION OF NEW YORK STATE,

Petitioner,

vs.

THE TRAVELERS INSURANCE COMPANY, ET AL.,

Respondents.

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UNITED STATES COURT OF APPEALS

FOR THE SECOND CIRCUIT

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Nos. 1514, 1515, 1516, 1667 August Term, 1992

(Argued: May 20, 1993 Decided: October 25, 1993)

Opinion Amended: JAN 14 1994

Docket Nos. 93-7132L, 93-7134CON, 93-7148CON, 93-7194XAP

- -x

THE TRAVELERS INSURANCE COMPANY,

Plaintiff-Appellee-Cross-Appellant,

HEALTH INSURANCE ASSOCIATION OF AMERICA, AMERICAN COUNCIL OF LIFE INSURANCE, LIFE INSURANCE COUNCIL OF NEW YORK, INC., AETNA LIFE INSURANCE CO., AETNA HEALTH PLANS OF NEW YORK, INC., MUTUAL OF OMAHA INSURANCE COMPANY, THE UNION LABOR LIFE INSURANCE COMPANY, PROFESSIONAL INSURANCE AGENTS OF NEW YORK, INC. TRUST,

Plaintiffs-Appellees,

NEW YORK STATE HEALTH MAINTENANCE ORGANIZATION CONFERENCE AND HEALTH SERVICES MEDICAL CORPORATION, MVP HEALTH PLAN, WELLCARE OF NEW YORK, MID-HUDSON HEALTH PLAN, OXFORD HEALTH PLAN, CAPITAL DISTRICT PHYSICIANS HEALTH PLAN, CHOICECARE LONG ISLAND, INDEPENDENT HEALTH, TRAVELERS OF NEW YORK, PHYSICIANS HEALTH SERVICES, PREFERRED CARE and U.S. HEALTHCARE,

Plaintiffs-Intervenors-Appellees,

v.

MARIO M. CUOMO, in his official capacity as Governor of the State of New York, MARK CHASSIN, M.D., in his official capacity as Commissioner of Health for the State of New York, SALVATORE R. CURIALE, in his official capacity as Superintendent of Insurance of the State of New York, MARY JO BANE, in her official capacity as Commissioner of Social Services of the State of New York, ROBERT ABRAMS, in his official capacity as Attorney General of the State of New York,

Defendants-Appellants-Cross-Appellees,

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, EMPIRE BLUE CROSS AND BLUE SHIELD, HOSPITAL ASSOCIATION OF NEW YORK STATE,

Intervenors-Defendants-Appellants-Cross-Appellees.

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Before: LUMBARD, CARDAMONE, and McLAUGHLIN, *Circuit Judges.*

Appeal and cross-appeal from a judgment of the United States District Court for the Southern District of New York (Louis J. Freeh, *Judge*), granting plaintiffs' motions for summary judgment in part and denying defendants' motions and cross-motions for summary judgment. The district court held, *inter alia*, that: (1) certain provisions of New York Public Health Law § 2807-c are preempted by ERISA, 29 U.S.C. §§ 1001-1461, and FEHBA, 5 U.S.C. §§ 8901-8914; and (2) ERISA also preempts parts of Actuarial Letter No. 5, issued by New York's Department of Insurance.

Affirmed in part; reversed in part.

M. PATRICIA SMITH, Ass't Attorney General, New York, NY (Robert Abrams, Attorney General of the State of New York, Jane Lauer Barker, Ass't Attorney General in Charge of Labor Bureau, New York, NY, of counsel), *for Defendants-Appellants-Cross-Appellees.*

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Association of America, American Council of Life Insurance, Life Insurance Council of New York, Inc., Mutual of Omaha Insurance Company, The Union Labor Life Insurance Company, Aetna Life Insurance Company and Aetna Health Plans of New York, Inc. and Professional Insurance Agents of New York, Inc. Trust.

HAROLD N. ISELIN, Albany, NY (Barbara S. Brenner, Steve T. Engelman, Couch, White, Brenner, Howard & Feigenbaum, Albany, NY, of counsel), *for Plaintiffs-Intervenors-Appellees New York State Health Maintenance Organization Conference, Capital District Physicians' Health Plan, Inc., Choicecare Long Island, Inc., Health Services Medical Corporation of Central New York, Inc., Independent Health Association, Inc., Mid-Hudson Health Plan, Inc., Mohawk Valley Physicians' Health Plan, Inc., Oxford Health Plans, Inc., Physicians Health Services of New York, Inc., Preferred Care, Inc., Travelers Health Network of New York, Inc., U.S. Healthcare, Inc., and Wellcare of New York, Inc.*

Stuart E. Schiffer, Acting Ass't Attorney General, Washington, DC (Roger S. Hayes, U.S. Attorney, Anthony J. Steinmeyer, Scott R. McIntosh, Appellate Staff, Civil Division, Dep't of Justice, Washington, DC, of counsel), *filed a brief on behalf of the United States as Amicus Curiae.*

Susan M. Green, Trial Attorney, U.S. Dep't of Labor, Washington, DC (Judith E. Kramer, Deputy Solicitor of Labor, Marc I. Machiz, Associate Solicitor, Plan Benefits Security Division, Karen L. Handorf, Counsel for Decentralized and Special Litigation, Eric G. Serron, Trial Attorney, U.S. Dep't of Labor, Washington, DC, of counsel), *filed a brief on behalf of the Secretary of Labor as Amicus Curiae.*

Hugh Barber, Ass't Attorney General, Hartford, CT (Richard Blumenthal, Attorney General of the State of Connecticut, Richard J. Lynch, Arnold I. Menchel, Paul J. Lahey, Phyllis E. Hyman, Ass't Attorneys General, Hartford, CT, of counsel), *filed a brief on behalf of the State of Connecticut as Amicus Curiae.*

Benjamin W. Boley, Washington, DC (William H. Dempsey, Shea & Gardner, Washington, DC, of counsel), *filed a brief on behalf of the National Carriers' Conference Committee as Amicus Curiae.*

Edward J. Groarke, Garden City, NY (Colleran, O'Hara & Mills, of counsel), *filed a brief on behalf of Trustees of and The Pension, Hospitalization Benefit Plan of the Electrical Industry and Trustees of and United Food and Commercial Workers Local 174 Health Care Fund, Trustees of and United Food and Commercial Workers Local 174 Retail Welfare Fund, and Trustees of and United Food and Commercial Workers Local 174 Commercial Health Care Fund as Amici Curiae.*

McLAUGHLIN, *Circuit Judge*:

Defendants Mario Cuomo *et al.* ("the State") and intervenors-defendants New York Conference of Blue Cross and Blue Shield Plans *et al.* appeal from a judgment of the United States District Court for the Southern District of New York (Louis J. Freeh, *Judge*), granting plaintiffs' motions for summary judgment in part and denying defendants' motions and cross-motions for summary judgment. *Travelers Ins. Co. v. Cuomo*, 813 F. Supp. 996 (S.D.N.Y. 1993).

The district court held that certain components of New York's inpatient hospital reimbursement system are preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001-1461 (1988 & Supp. IV 1992), and the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. §§ 8901-8914 (1988 & Supp. IV 1992). In particular, the district court invalidated three subsections of New York Public Health Law § 2807-c (McKinney Supp. 1993) imposing surcharges on the hospital rates for certain categories of payors, and not others. The district court also held that ERISA preempts ¶¶ 1, 2, 3, and 5 of Actuarial Letter No. 5, issued by New York's Department of Insurance.

The Travelers Insurance Company ("Travelers") cross-appeals, contending that the district court should also have granted its motion for summary judgment as to ¶ 4 of the Actuarial Letter, as well. We agree with Travelers and reverse that portion of the judgment which held that ¶ 4 is not preempted by ERISA. In all other respects, we affirm.

BACKGROUND

Eighty-eight percent of non-elderly Americans have private health care insurance through their employee welfare benefit plans. ERISA is the governing statute. ERISA plans provide health coverage to employees in various ways, including: (1) the purchase of commercial health insurance from an insurer; (2) self-insurance, whereby the plan is directly responsible for health

care bills and usually carries excess liability coverage known as "stop-loss" coverage; (3) subscription to a health maintenance organization ("HMO"); and (4) coverage through non-profit health service corporations, such as Blue Cross/Blue Shield plans (the "Blues").

Whereas ERISA regulates employee benefit plans of private employers, FEHBA establishes a comprehensive program to provide federal employees, their families, and federal retirees (collectively, "enrollees") with subsidized health care benefits. Under FEHBA, the United States does not act as an insurer, but, through the Office of Personnel Management ("OPM"), contracts with various insurance carriers to develop health care plans with varying coverages and costs. 5 U.S.C. § 8902. Prospective enrollees can select coverage from any one of the participating carriers in their region. 5 U.S.C. § 8905. Among the numerous plaintiffs in this action, only Mutual of Omaha Insurance Company underwrites and administers a FEHBA health benefit plan covering federal enrollees who receive inpatient hospital care in New York.

Any patient entering a hospital is placed in a category known as a diagnosis-related group ("DRG"), based on his symptoms and probable cost of treatment. The amount the hospital may charge for the patient's care is based on the DRG, not the actual cost of treatment. New York law provides that the DRG amount charged to a particular patient is then increased by a "payor factor," depending on the type of health care coverage the patient has. This, of course, results in a "differential" in the charges, depending on which type of health care coverage the patient has.

Since its enactment in 1988, New York Public Health Law § 2807-c(1)(b) has required that insurance carriers of patients covered by any form of health plan other than the Blues, an HMO, or government insurance such as Medicaid must pay 13% above the DRG rate. The 13% differential, which is kept by the hospital, was enacted to contain hospital costs and to increase the availability of hospital insurance coverage to needy New Yorkers. In particular, the differential was meant to " 'level [the]

playing field' " for the Blues "in their competition with commercial insurers." Joint Appendix at 649; Clyne Aff. ¶ 15. The hope was that this would encourage more employers and ERISA plans to subscribe to the Blues.

The New York Omnibus Revenue Act of 1992 imposed two more surcharges: (1) an additional 11% surcharge on DRG payment rates charged to patients covered by commercial insurance, 1992 N.Y. Laws, ch. 55, § 348 (codified as amended at N.Y. Pub. Health Law § 2807-c(11)(i) (McKinney Supp. 1993)); and (2) an assessment of up to 9% on HMOs which fail to enroll a target number of Medicaid-eligible persons. 1992 N.Y. Laws, ch. 55, § 346 (codified as amended at N.Y. Pub. Health Law § 2807-c(2-a)(a) (McKinney Supp. 1993)). Unlike the basic 13% differential, the proceeds of the 11% surcharge are not kept by the hospital, but are paid into a statewide pool, which is then deposited into the State's general fund. HMOs, in contrast, must pay their 9% assessment directly into a statewide HMO pool, but it too ultimately winds up in the State's coffers.

The obvious effect of the 11% surcharge is to increase commercial insurers' costs of providing health care, thus making them less competitive with the Blues. Unlike the 11% surcharge, however, the primary purpose of the 9% assessment is to encourage HMOs to enroll Medicaid recipients, thereby lowering the costs of the Medicaid program.

Besides imposing surcharges, New York's Department of Insurance has issued "Actuarial Information Letter No. 5," regulating how self-insured plans obtain "stop-loss" insurance. The Letter: (1) permits a self-insured to obtain stop-loss insurance only if the plan provides its members with statutorily mandated services; (2) requires that self-insured plans provide beneficiaries with the right to a statutory conversion policy; and (3) requires self-insured plans to afford members various protections in case the plan becomes insolvent.

In separate actions, several commercial insurers and insurance industry trade associations, including Travelers and the Health Insurance Association of America ("HIAA"), sued various New

York State authorities for declaratory and injunctive relief, complaining that all three surcharges and the Actuarial Letter are preempted by ERISA, and the 13% and 11% surcharges are also preempted by FEHBA. The New York State Conference of Blue Cross and Blue Shield Plans, Empire Blue Cross and Blue Shield (collectively, the "Blues Conference"), and the Hospital Association of New York State ("HANYS") intervened as defendants; the New York State Health Maintenance Organization Conference and several HMOs intervened as plaintiffs. Thereafter, the parties cross-moved for summary judgment, and the district judge then consolidated the various actions.

The district court granted most of the relief that plaintiffs sought, holding that: (1) the Tax Injunction Act does not preclude an injunction against the 11% and 9% surcharges; (2) ERISA preempts all three surcharges; (3) FEHBA preempts the 13% and 11% surcharges; (4) plaintiffs' claims as to the 13% surcharge are not barred by the doctrine of laches; and (5) ¶¶ 1, 2, 3, and 5 of the Actuarial Letter are also preempted by ERISA. The court enjoined the defendants from enforcing the surcharges and the Actuarial Letter against the appropriate payors, but then stayed its ruling insofar as it enjoined the State from enforcing the 13% surcharge. Defendants appeal and plaintiff Travelers cross-appeals.

DISCUSSION

To promote clarity, we divide our analysis into four segments: (1) whether the district court had jurisdiction over these actions; (2) whether the equitable defense of laches raised by intervenor HANYS has merit; (3) whether FEHBA preempts the 13% and 11% surcharges; and (4) finally, we address the chief argument advanced in support of reversal, ERISA preemption.

I. *Jurisdiction*

The Tax Injunction Act ("TIA") provides that federal district courts "shall not enjoin, suspend, or restrain the assessment . . . of any tax under State law where a plain, speedy and efficient remedy may be had in the courts of such State." 28 U.S.C. § 1341

(1988); *see Kraebel v. New York City Dep't of Hous. Preservation & Dev.*, 959 F.2d 395, 400 (2d Cir.) (TIA "bars federal injunctive challenges to state tax laws in federal courts."), *cert. denied*, 113 S. Ct. 326 (1992). This prohibition includes "declaratory as well as injunctive relief." *Barringer v. Griffes*, 964 F.2d 1278, 1280 (2d Cir. 1992).

The district court held that the TIA did not apply to the 11% and 9% surcharges, and therefore, it had jurisdiction. Two conditions must be satisfied to invoke the protection of the TIA: first, the surcharges must constitute "taxes,"[1] and second, the state remedies available to plaintiffs must be "plain, speedy and efficient." *See Kraebel*, 959 F.2d at 400.

A. *Taxes*

The district court "assumed" that the 11% and 9% surcharges were "taxes" under the TIA, stating "to the extent that [these] [s]urcharges are paid into New York's General Fund, they appear to be taxes." 813 F. Supp. at 1000 & n.1 (citation omitted). Although there is no bright line between assessments that are taxes and those that are not, most courts agree that "[a]ssessments which are imposed primarily for revenue-raising purposes are 'taxes,' while levies assessed for regulatory or punitive purposes, even though they may also raise revenues, are generally not 'taxes.' " *Butler v. Maine Supreme Judicial Court*, 767 F. Supp. 17, 19 (D. Me. 1991) (collecting cases). In general, courts "have tended . . . to emphasize the revenue's ultimate use, asking whether it provides a general benefit to the public, of a sort often financed by a general tax, or whether it provides more narrow benefits to regulated companies or defrays the agency's costs of regulation." *San Juan Cellular Tel. Co. v. Public Serv. Comm'n*, 967 F.2d 683, 685 (1st Cir. 1992).

It is apparent that the 11% and 9% surcharges are taxes. Notwithstanding the primary purposes ascribed to the surcharges by the State, both raise revenue which is ultimately paid into

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[1] The Blues Conference does not argue that the 13% differential is a "tax" for good reason: its proceeds are retained by the hospitals and not deposited into the State treasury.

the State's general fund. Thus, because the contested surcharges serve general revenue-raising purposes, they constitute "taxes" for purposes of the TIA. *See, e.g., Keleher v. New England Tel. & Tel. Co.*, 947 F.2d 547, 549 (2d Cir. 1991) (the word "tax" under the TIA "encompasses any state or local revenue collection device," including a city-assessed public utility "franchise fee" because the money raised was treated as part of the city's "general revenue"); *Butler*, 767 F. Supp. at 19 (nonrefundable jury fee required in Maine state courts "fits comfortably within [the] definition of a 'tax' under section 1341" because "the fees collected will be funneled into Maine's general fund, rather than being applied directly to the costs of jury trials.").

B. *State Remedy*

The district court found that plaintiffs did not have a "plain, speedy and efficient remedy" in New York state court "[b]ecause ERISA generally confers exclusive jurisdiction on the federal courts." 813 F. Supp. at 1001 (relying upon *National Carriers' Conference Comm. v. Heffernan*, 440 F. Supp. 1280, 1283 (D. Conn. 1977)). Plaintiffs sued here as plan fiduciaries to enjoin a practice violating ERISA. Congress has divested the state courts of jurisdiction over such claims. *See* 29 U.S.C. § 1132(e)(1) (1988); *see also Shofer v. Hack Co.*, 970 F.2d 1316, 1319 (4th Cir. 1992) (where ERISA claims are within the exclusive jurisdiction of the federal courts, state courts are plainly without jurisdiction). Thus, "[b]ecause the [New York] courts lack the jurisdiction to decide the plaintiffs' injunctive and declaratory ERISA claims, the plaintiffs are without a 'plain, speedy and efficient' remedy at state law." *Thiokol Corp. v. Department of Treasury, Revenue Div.*, 987 F.2d 376, 380 (6th Cir. 1993); *accord E-Systems, Inc. v. Pogue*, 929 F.2d 1100, 1102 (5th Cir.) (TIA is "inapplicable" in an ERISA setting), *cert. denied*, 112 S. Ct. 585 (1991).

Accordingly, we conclude that the district court did not err in finding that the state remedies available to plaintiffs were inadequate, and thus it had jurisdiction over plaintiffs' claims.

II. *Laches*

New York's complex reimbursement system has had a differential among various payors since the late 1970s. A statutory

differential has existed since 1983. Hence, intervenor HANYS contends that plaintiffs' current challenge to the 13% differential is barred by laches.

Laches is an equitable defense that applies when "a plaintiff unreasonably delayed in initiating an action and a defendant was prejudiced by the delay." *Robins Island Preservation Fund, Inc. v. Southold Dev. Corp.*, 959 F.2d 409, 423 (2d Cir.) (citations omitted), *cert. denied*, 113 S. Ct. 603 (1992). We review a district court's application of the laches doctrine for an abuse of discretion, *see King v. Innovation Books, Div. of Innovative Corp.*, 976 F.2d 824, 832 (2d Cir. 1992), and we find no abuse here.

In our view, there was a legitimate reason for plaintiffs' delay in mounting this challenge. *See Stone v. Williams*, 873 F.2d 620, 624 (2d. Cir.) ("[I]t is the reasonableness of the delay rather than the number of years that elapsed which is the focus of the [laches] inquiry."), *cert. denied*, 493 U.S. 959, *and vacated on other grounds*, 891 F.2d 401 (2d Cir. 1989), *cert. denied*, 496 U.S. 937 (1990). Almost ten years ago, in *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985), we rejected a claim that ERISA preempted New York's regulatory scheme governing hospital rates.

Rebaldo, while probably distinguishable, created little hope for the success of future challenges to New York's reimbursement system. Prospects of success improved only recently because of Supreme Court cases which, as will be discussed *infra*, undermine *Rebaldo*. Immediately after *Rebaldo*, instead of challenging the 13% differential in court, plaintiffs changed their tactics and sought a legislative remedy, instead. Only when these legislative efforts failed in 1992 with the enactment of an additional 11% surcharge did they sue the State. This is not a tableau of unreasonable delay. Accordingly, we find no error in the district court's rejection of the laches defense.

III. *FEHBA Preemption*

Adopted as part of the Omnibus Budget Reconciliation Act of 1990 ("OBRA"), Pub. L. No. 101-508, § 7002(c), 104 Stat. 1388,

1388-330 (1990) (codified without title of §7002(c) at 5 U.S.C. §8909(f) (Supp. IV 1992) (amending 5 U.S.C. § 8909 (1988)), FEHBA's preemption provision is contained in §8909(f)(1):

> No tax, fee, or other monetary payment may be imposed, directly or indirectly, on a carrier or an underwriting or plan administration subcontractor of an approved health benefits plan by any State, the District of Columbia, or the Commonwealth of Puerto Rico, or by any political subdivision or other governmental authority thereof, with respect to any payment made from the Fund.

The district court found this provision ambiguous. Finding the statute's legislative history equally unenlightening, it invoked the teachings of *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-43 (1984) (absent clear congressional intent, district courts should defer to implementing agency's interpretation of a federal statute, as long as that interpretation is reasonable). Thus, the court turned to OPM for guidance. It concluded that OPM's determination that the surcharges are preempted under §8909(f)(1) was a reasonable construction of the statute and deferred to that interpretation by holding FEHBA preempted the 13% and 11% surcharges.

On appeal, defendants renew the argument that "the language of the statute as well as its legislative history are unambiguous, and reflect Congress' clear intent that FEHBA preemption apply only to state premium taxes." 813 F. Supp. at 1010; *see* 48 C.F.R. § 1652.216-71 (1992) (defining "premium taxes" as those "imposed on FEHB premiums by any State, the District of Columbia, or the Commonwealth of Puerto Rico"). They point to the statute's legislative history and the title of § 7002(c) – "EXEMPTION FROM STATE PREMIUM TAXES" – and conclude that § 8909(f)(1) is targeted only at premium taxes, and not the surcharges here. We are not persuaded.

We start by looking at the plain language of a statute to interpret its ordinary common meaning. *See Connecticut Nat'l*

Bank v. Germain, 112 S. Ct. 1146, 1149 (1992) ("courts must presume that a legislature says in a statute what it means and means in a statute what it says"). "If the words of a statute are unambiguous, judicial inquiry should end, and the law interpreted according to the plain meaning of its words." *Aslanidis v. United States Lines, Inc.*, 7 F.3d 1067, 1073 (2d Cir. 1993). In our view, the language of § 8909(f)(1) is sufficiently clear to reveal congressional intent. *See Ardestani v. INS*, 112 S. Ct. 515, 520 (1991) (strong presumption that plain language of statute expresses legislative intent).

By its terms, 5 U.S.C. § 8909(f)(1) prohibits [1] every state or local "tax, fee, or other monetary payment" [2] imposed, "directly or indirectly," on a "carrier or an underwriting or plan administration subcontractor of an approved [FEHBA] health benefits plan," [3] "with respect to any payment made from the Fund." Defendants do not dispute that the 13% and 11% surcharges satisfy the first two requirements for preemption: the surcharges are a state-imposed "tax, fee, or other monetary payment," and they are imposed "directly or indirectly" on carriers offering FEHBA plans. The controversy, therefore, is over the third one – the requirement that the tax is imposed "with respect to any payment made from the Fund."

Under FEHBA, the federal government and individual enrollees make "contributions" which are then deposited into the Employees Health Benefits Fund (the "Fund") in the United States Treasury. 5 U.S.C. §§ 8906, 8909 (1988 & Supp. IV 1992). The Fund is administered by OPM. *Id.*

OPM contracts with various insurance carriers, and through various health benefit plans the carriers provide, pay for, or reimburse the cost of health services for enrollees. 5 U.S.C. §§ 8901(6), 8901(7), and 8902(a) (1988). In turn, OPM creates a letter of credit ("LOC") account for each experience-rated plan,[2] and the

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[2] Contribution rates for an experience-rated plan are based on the plan's actual paid claims, administrative expenses, and other allowable "retentions."

(Footnote continued)

LOC is maintained in the Treasury as part of the Fund. Each carrier draws against its LOC account on a "checks-presented" basis for amounts paid by the carrier as FEHBA claims or expenses. 5 U.S.C. § 8909(a) (Supp. IV 1992); 48 C.F.R. § 1632.170(b)(2) (1992). This requires carriers to pay for covered hospital treatment from their own resources, and then get reimbursed by drawing against their LOC. *Cf.* 48 C.F.R. § 1632.170(b)(2) ("[D]rawdown on the LOC is delayed until the checks issued for FEHB Program disbursements are presented to the carrier's bank for payment.").

Given this scheme of payment and reimbursement, and mindful of how the two reserves required for each experience-rated plan work, *see* 5 U.S.C. § 8909(b)(2) (Supp. IV 1992); 5 C.F.R. §§ 890.503(c)(1)-(2) (1993) ("contingency" reserve); 5 C.F.R. § 890.503(c)(3) (1993) ("carrier" reserve), the preemption issue is not a difficult one. The 13% and 11% surcharges are, indeed, imposed "with respect to any payment made from the Fund" because the amount drawn by experience-rated carriers from their LOC accounts, which are part of the Fund, is based in part on the amount of the surcharge. As already noted, carriers first pay hospital bills from their own funds, then draw from their LOC accounts to replenish their depleted funds. Because payments from the Fund are directly affected by what the hospitals charge for their services, and because the surcharges increase the amounts carriers draw from the Fund, the surcharges are clearly imposed "with respect to. . . payment[s] made from the Fund." Accordingly, they are preempted.

Despite this straightforward construction of § 8909(f)(1), defendants urge us to reject it because our interpretation is repugnant to the general aims of FEHBA. They believe that there

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See 48 C.F.R. § 1602.170-6 (1992) (defining "[e]xperience rate"). In contrast, a "*[c]ommunity rate* means a rate of payment based on a per member per month capitation rate or its equivalent that applies to a combination of the subscriber groups for a comprehensive medical plan." 48 C.F.R. § 1602.170-2(a) (1992).

Because the FEHBA preemption issue in this case involves only experience-rated plans, we need not reach the issue as to community-rated plans.

is a clearly expressed legislative intention that is contrary to the language of the statute. *Cf. United States v. Ron Pair Enters., Inc.*, 489 U.S. 235, 242 (1989) ("The plain meaning of legislation should be conclusive, except in the 'rare cases [in which] the literal application of a statute will produce a result demonstrably at odds with the intentions of its drafters.' " (citation omitted)).

In plumbing the legislative history of § 8909(f)(1), defendants selectively ignore legislative policies that run counter to their interpretation of the statute. Section 8909(f)(1) was enacted as part of OBRA, the central purpose of which was to reduce government expenditures. *See* H. Rep. No. 101-881, 101st Cong., 2d Sess. 169 (1990), *reprinted in* 1990 U.S.C.C.A.N. 2017, 2177. For its part, § 8909(f)(1) was designed to reduce expenditures from the Fund by preventing states from charging taxes on health care reimbursements drawn by carriers from the Fund. *Id.* at 173, *reprinted in* 1990 U.S.C.C.A.N. at 2181. To adopt defendants' crabbed view of preemption would undermine this revenue-saving purpose.

Defendants cite numerous excerpts from congressional committee reports where § 8909(f)(1) is characterized as a restriction on "premium taxes." This exercise is singularly unenlightening, however, because it remains obscure what the various members of Congress meant when they referred to "premium taxes" in discussing § 8909(f)(1). We also note that defendants' reliance on the title to § 7002(c) of OBRA containing § 8909(f) as an amendment to FEHBA is misplaced. Defendants simply ignore that the focal point of this controversy is FEHBA § 8909(f)(1), and not OBRA § 7002(c).

Finally, defendants are piqued that the district court deferred to OPM's current interpretation of the preemption issue. (This interpretation is set forth in the government's *amicus* brief and affidavits, and was first solicited by the State from OPM (in opinion letters) before this action even began.) Defendants argue that the district court ignored an earlier OPM regulation limiting the scope of § 8909(f) to "premium taxes," 48 C.F.R. § 1631.205-41 (1992), and instead improperly deferred to OPM's

current interpretation which defendants characterize as " 'agency litigating positions that are wholly unsupported by regulations, rulings, or administrative practice.' " State's Brief at 44 (quoting *Bowen v. Georgetown University Hospital*, 488 U.S. 204, 212 (1988)).

Even if we agreed that the language of § 8909(f)(1) is ambiguous and its legislative history unilluminating, we would still affirm the district court's judgment, with its reliance on OPM's *amicus* position. As a preliminary matter, the district court did not defer to an "agency litigating position"; rather, it deferred to OPM's administrative interpretation of § 8909(f)(1), made before the government entered this litigation and offered in response to a request from New York itself.

OPM in its *amicus* brief to this Court asserts that 48 C.F.R. § 1631.205-41 uses "premium taxes" as a shorthand description of the taxes covered by 5 U.S.C. § 8909(f)(1), not in the narrow sense urged by defendants. The regulation stresses, in OPM's view, the broad sweep of § 8909(f), interpreting it to apply to "*all* payments directed by States or municipalities, regardless of how they may be titled, to whom they must be paid, or the purpose for which they are collected," including "*all* forms of direct and indirect measurement of FEHBP premiums, *however modified* . . . ." 48 C.F.R. § 1631.205-41 (emphasis added). Like the district court, we too will defer to OPM's interpretation of its own regulation unless it "is . . . plainly erroneous or inconsistent with the language of the regulation." *Federal Labor Relations Auth. v. United States Dept. of Veterans Affairs*, 958 F.2d 503, 514 (2d Cir. 1992) (citing *Robertson v. Methow Valley Citizens Council*, 490 U.S. 332, 359 (1989)). We cannot say it is unreasonable to interpret § 1631.205-41 as OPM does.

Accordingly, the New York statutes imposing the 13% and 11% surcharges are preempted by FEHBA.

IV. *ERISA Preemption*

Whether a particular state statute is preempted by ERISA is a question of statutory interpretation, as informed by

congressional intent. With understated irony, the Supreme Court has described the ERISA section at issue here as "not a model of legislative drafting." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985). In truth, it is a veritable Sargasso Sea of obfuscation:

> **(a) Supersedure; effective date**
>
> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter *relate to* any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. . . .
>
> **(b) Construction and application**
>
> . . . .
>
> (2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which *regulates insurance*, banking, or securities.
>
> (B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be *deemed* to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

29 U.S.C. § 1144(a)-(b)(2)(B) (1988) (emphasis added).

The opening paragraph is the *preemption* clause. The next paragraph [(b)(2)(A)] is the *saving* clause. And the final

paragraph [(b)(2)(B)] has come to be known as the *deemer* clause. *See FMC Corp. v. Holliday*, 498 U.S. 52, 57-58 (1990).

Setting sail, we begin with the observation that ERISA is a comprehensive federal statutory scheme regulating "private employee benefits plans, including both pension and welfare plans." *District of Columbia v. Greater Wash. Bd. of Trade*, 113 S. Ct. 580, 582 (1992). "A 'welfare plan' is defined . . . to include, *inter alia*, any 'plan, fund, or program' maintained for the purpose of providing medical or other health benefits for employees or their beneficiaries 'through the purchase of insurance or otherwise.' " *Id.* (quoting 29 U.S.C. § 1002(1)). While the statute does not mandate particular benefits, it " 'sets various uniform standards, including rules concerning reporting, disclosure, and fiduciary responsibility, for . . . welfare plans.' " *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 137 (1990) (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 91 (1983) (citation omitted)).

ERISA expressly preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by the statute. 29 U.S.C. § 1144(a) (the preemption clause). This sweeping provision is not without qualification and, pertinent to this case, excepts from preemption those state laws that "regulate insurance," 29 U.S.C. § 1144(b)(2)(A) (the saving clause), except as further provided in the deemer clause, stating that an employee benefit plan governed by ERISA shall not be "deemed" an insurance company, an insurer, or "engaged in the business of insurance . . . for purposes of any [state law] purporting to regulate" insurance companies or insurance contracts. 29 U.S.C. § 1144(b)(2)(B); *see FMC Corp.*, 498 U.S. at 58.

The district court concluded that all the surcharges, as well as ¶¶ 1, 2, 3, and 5 of the Actuarial Letter "relate to" employee benefit plans within the meaning of ERISA's preemption clause. The court also found that the surcharges are not preserved by the saving clause as laws that "regulate insurance;" and, without considering whether the Actuarial Letter regulates insurance, the court also concluded that the deemer clause precluded any

state regulation of self-funded plans. Accordingly, the district court held that ERISA preempted the three surcharges and also ¶¶ 1, 2, 3, and 5 of the Actuarial Letter. For the reasons set forth below, we substantially agree.

The Supreme Court has "repeatedly stated that a law 'relate[s] to' a covered employee benefit plan for purposes of [the preemption clause] 'if it has a connection with or reference to such a plan.' " *Greater Wash. Bd. of Trade*, 113 S. Ct. at 583 (quoting *Shaw*, 463 U.S. at 97) (citations omitted). The term "relate to" is to be accorded "its broad common-sense meaning," *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47 (1987), thereby giving "effect to the 'deliberately expansive' language chosen by Congress." *Greater Wash. Bd. of Trade*, 113 S. Ct. at 583 (quoting *Pilot Life*, 481 U.S. at 46). "Under this 'broad common-sense meaning,' a state law may 'relate to' a benefit plan, and thereby be pre-empted, even if the law is not specifically designed to affect such plans or the effect is only indirect," *Ingersoll-Rand*, 498 U.S. at 139, and even if the law is "consistent with ERISA's substantive requirements." *Metropolitan Life Ins.*, 471 U.S. at 739. Accordingly, we have held that "a state law of general application, with only an indirect effect on a pension plan, may nevertheless be considered to 'relate to' that plan for preemption purposes." *Smith v. Dunham-Bush, Inc.*, 959 F.2d 6, 9 (2d Cir. 1992).

On the other hand, the Court has also recognized that "[s]ome state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan," *Shaw v. Delta Air Lines, Inc.*, 463 U.S. at 100 n.21 (1983), "as is the case with many laws of general applicability." *Greater Wash. Bd. of Trade*, 113 S. Ct. at 583 n.1. *See, e.g., Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988) (generally applicable garnishment law under which creditors can garnish ERISA welfare benefits not preempted); *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987) (law requiring companies to make lump-sum severance payments when closing a plant not preempted); *Aetna Life Ins. Co. v. Borges*, 869 F.2d 142 (2d Cir.) (application of escheat law to ERISA-covered benefit checks and drafts issued but not collected

or presented for payment by beneficiaries not preempted), *cert. denied*, 493 U.S. 811 (1989).

On appeal, defendants contend that "the [s]urcharges do not 'relate to' ERISA plans within the meaning of ERISA's preemption clause because they are laws of general application, which have only a peripheral impact on the plans." 813 F. Supp. at 1005. In making this argument, defendants rely on *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985) and fault the district court for its conclusion that *Rebaldo* "has been abrogated by later Supreme Court cases." 813 F. Supp. at 1005.

Rebaldo held that ERISA did not preempt certain New York regulations governing the right of self-insured employee benefit plans to negotiate discounts with hospitals. In rejecting this challenge, we initially found that "a state law must '*purport*[] to regulate, . . . the terms and conditions of employee benefit plans' to fall within the preemption provision" of ERISA. *Rebaldo*, 749 F.2d at 137 (quoting 29 U.S.C. § 1144(c)(2)) (emphasis added). *Rebaldo* went on to hold that the impact of New York's regulations on ERISA benefit plans was too tenuous, remote, and peripheral to require preemption. *Id.* at 138. Six years later, in *Ingersoll-Rand*, 498 U.S. at 141, the Supreme Court expressly rejected the notion that Congress intended to limit ERISA's preemptive effect to state laws *purporting* to regulate plan terms and conditions. *See Smith*, 959 F.2d at 9 & n.3 (following *Ingersoll-Rand*, rejecting "purports to regulate" standard). Despite *Ingersoll-Rand*, defendants continue to argue that *Rebaldo*'s analysis of what triggers ERISA preemption is still controlling.

We have little difficulty agreeing with the district court that *Rebaldo*'s fundamental premise was rejected by the Supreme Court. In our view, *Rebaldo*'s entire analysis is poisoned by its discredited belief that ERISA's preemption clause is targeted only at state laws that "purport to regulate" plan terms and conditions. Therefore, we conclude that defendants' reliance on *Rebaldo* is misplaced.

A. *The Surcharges: Preemption*

Defendants maintain that the district court erred in concluding that the challenged statutes' indirect economic impact upon ERISA plans was substantial and impermissibly affected the structure, the administration, or the type of benefits furnished by a plan. We disagree. While the challenged statutes do not refer to ERISA plans, *see Mackey*, 486 U.S. at 831 (statute need not specifically mention ERISA plans to be preempted), our examination of the surcharges indicates that they satisfy the less stringent "connection with" standard embraced in *Ingersoll-Rand*.

The 13% and 11% surcharges are designed to increase hospital costs for patients covered by health plans other than the Blues, and thus make these competing plans less attractive than the Blues. Obviously, the surcharges will affect ERISA plans' health care benefits. Likewise, the 9% assessment imposed on HMOs will interfere with a plan's selection of the most effective method to provide benefits. Thus, the surcharges purposely interfere with the choices that ERISA plans make for health care coverage. Such interference is sufficient to constitute "connection with" ERISA plans. *See, e.g., National Elevator Indus., Inc. v. Calhoon*, 957 F.2d 1555, 1561 (10th Cir.) (ERISA preempts administrative interpretation of Oklahoma's prevailing wage statute insofar as it determines rates of pay and "may be used to effect change in the administration, structure and benefits of an ERISA plan"), *cert. denied*, 113 S. Ct. 406 (1992); *In re Michigan Carpenters Council Health & Welfare Fund*, 933 F.2d 376, 382-83 (6th Cir.) (ERISA preempts Michigan state corporate reorganization statute that allows employers unilaterally to alter their obligation to ERISA plans), *cert. denied*, 112 S. Ct. 585 (1991); *National Carriers' Conference Comm. v. Heffernan*, 440 F. Supp. 1280 (D. Conn. 1977) (Connecticut tax on ERISA benefits preempted since it may encourage use of traditional insurance rather than ERISA-covered plans); *Morgan Guar. Trust Co. v. Tax Appeals Tribunal of Dep't of Taxation & Finance*, 80 N.Y.2d 44, 51, 587 N.Y.S.2d 252, 256, 599 N.E.2d 656, 660 (1992) (New York real estate gains tax preempted as applied to sale of ERISA property because tax will influence plans' investment strategy).

The surcharges substantially increase the cost to ERISA plans of providing beneficiaries with a given level of health care benefits. Under similar circumstances, the Fifth Circuit held that a state statute imposing a 2.5% tax on administrative and service fees was preempted by ERISA. *E-Systems, Inc. v. Pogue*, 929 F.2d 1100 (5th Cir.), *cert. denied*, 112 S. Ct. 585 (1991). The court found that the tax was related to ERISA plans because: "The cost of the plan must therefore increase for the employer and/or employees or the benefits must be adjusted downwards to offset the tax bite. This is the type of impact Congress intended to avoid when it enacted the ERISA legislation." *Id.* at 1103.

As in *E-Systems*, the surcharges here force ERISA plans to increase either plan costs or reduce plan benefits. Therefore, they have the requisite connection to ERISA. *See also General Electric Co. v. New York State Dep't of Labor*, 891 F.2d 25, 28 (2d Cir. 1989) (New York Labor Law governing wage requirements was preempted where it required employers to pay certain benefits, because " 'private parties, not the Government, control the level of benefits' " under ERISA) (quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 511 (1981)), *cert. denied*, 496 U.S. 912 (1990); *cf. Arkansas Blue Cross & Blue Shield v. St. Mary's Hosp., Inc.*, 947 F.2d 1341, 1348 (8th Cir. 1991) ("Like all the factors considered, . . . simply because the existence of some economic impact is not dispositive of the preemption issue does not make this factor irrelevant to the preemption inquiry."), *cert. denied*, 112 S. Ct. 2305 (1992).

In making its finding that the surcharges are related to ERISA, the district court focused on plaintiffs' claims that they would pass along the higher costs associated with the surcharges, which might in turn lead plans to reduce their level of service or benefits. Defendants and the Department of Labor as *amicus* contend that the indirect and inevitably speculative economic impact of the challenged statutes *alone* does not justify a finding of preemption. They argue that the Supreme Court has never held that indirect economic impact, standing alone, is sufficient to justify a finding of preemption. *See, e.g., Mackey*, 486 U.S. at 830-41 (indirect economic effect of state garnishment

law not enough to warrant preemption); *see also Aetna Life*, 869 F.2d at 146 ("where a state statute of general application 'does not affect the structure, the administration, or the type of benefits provided by an ERISA plan, the mere fact that the statute has some economic impact on the plan does not require that the statute be invalidated.' " (quoting *Rebaldo*, 749 F.2d at 139)).

The Blues Conference, in particular, relies on *NYSA-ILA Medical & Clinical Servs. Fund v. Axelrod*, No. 92 Civ. 2779 (JSM), 1993 WL 51146, at *4 (S.D.N.Y. Feb. 23, 1993) ("The tax is not great enough to pose a serious economic threat to the plan which might trigger preemption."). There, Judge Martin rejected an ERISA plan's challenge to New York's Health Facility Assessment ("HFA") because its economic impact on the plan was *de minimis*. The court distinguished *Morgan Guaranty Trust*, 80 N.Y.2d 44, 587 N.Y.S.2d 252, 599 N.E.2d 656, on the ground that the New York case involved a "substantial" tax of 10% of the consideration received for the realty sold therein, as opposed to the HFA of 0.6% of gross receipts to which the HFA was applicable. Further, Judge Martin in *NYSA-ILA* explicitly compared the result Judge Freeh reached in this case, with its surcharges of 13%, 11%, and 9% on hospital DRGs. *See NYSA-ILA*, 1993 WL 51146, at *4. Thus, the *NYSA-ILA* court recognized that a *substantial* economic impact, standing alone, could be enough to bring ERISA's preemption clause into play.

In sum, Judge Freeh properly found that the three surcharges "relate to" ERISA because they impose a significant economic burden on commercial insurers and HMOs. They therefore have an impermissible impact on ERISA plan structure and administration.[3] Accordingly, the statutes at issue here are

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[3] To the extent that our holding conflicts with *United Wire, Metal & Machine Health & Welfare Fund v. Morristown Memorial Hosp.*, 995 F.2d 1179 (3rd Cir.), *cert. denied*, 114 S. Ct. 382, *and cert. denied*, 114 S. Ct. 382, *and cert. denied*, 114 S. Ct. 382, *and cert. denied*, 114 S. Ct. 383 (1993), we decline to follow it. In that case, several self-insured union employee welfare benefit plans sued numerous New Jersey hospitals and various New Jersey State

(Footnote continued)

preempted – unless they are salvaged by ERISA's saving clause as a law that regulates insurance. 29 U.S.C. § 1144(b)(2)(A).

B. *The Surcharges: Saving Clause*

To determine whether a state law regulates insurance within the meaning of the saving clause, a court must first "consider the 'common-sense view' of the term 'regulates insurance' which suggests that 'in order to regulate insurance, a law must not just have an impact on the insurance industry, but must be *specifically* directed toward that industry.'" *Howard v. Gleason Corp.*, 901 F.2d 1154, 1158 (2d Cir. 1990) (quoting *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50 (1987)). The court must next assess whether the law satisfies the three criteria developed for determining whether a practice constitutes "the business of insurance" within the meaning of the McCarran-Ferguson Act, 15 U.S.C.

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authorities for injunctive relief, complaining that New Jersey's statutory scheme for setting hospital rates was preempted by ERISA. The rate-setting statute at issue imposed additional surcharges on DRG rates to compensate hospitals for providing "uncompensated care" and treating Medicare patients, and granted discounts to certain classes of payors.

The Third Circuit held that the rate-setting statute "does not relate to the plans in a way that triggers ERISA's preemption clause." *Id.* at 1191. In brief, the court found that the connection between the statute and ERISA plans was too tenuous and remote "[b]ecause we are here dealing with a statute of general applicability that is designed to establish the prices to be paid for hospital services, which does not single out ERISA plans for special treatment, and which functions without regard to the existence of such plans," *id.* at 1192, and the statute's "indirect ultimate effect of increasing plan costs" places it beyond the scope of ERISA preemption. *Id.* at 1193-95.

Ironically, in reaching its conclusion, the Third Circuit relied heavily on our opinion in *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985). As we discuss above, however, we believe that decisions of the Supreme Court since *Rebaldo* have significantly eroded the premise upon which *Rebaldo* was decided. More generally, however, we also believe that the Third Circuit reads ERISA's preemption clause too narrowly. *See United Wire*, 995 F.2d at 1196-1203 (Nygaard, J., dissenting).

§§ 1011-1015 (1988 & Supp. IV 1992).[4] *See Pilot Life*, 481 U.S. at 48. Those criteria are: " '*First*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry.' " *Id.* at 48-49 (quoting *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982)).

Applying these tests, we conclude, first of all, that the 13% and 11% surcharges do not "regulate insurance" within the meaning of the saving clause.[5] Our common-sense inquiry reveals

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[4] The McCarran Act was enacted in 1945 to help resolve federalism concerns over the roles of federal and state governments in regulating insurance. Now known as the McCarran-Ferguson Act, it provides, in relevant part:

> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided*, That [the Sherman Act, the Clayton Act, and the Federal Trade Commission Act] shall be applicable to the business of insurance to the extent that such business is not regulated by State Law.

15 U.S.C. § 1012(b).

[5] The Department of Labor ("DOL") argues that the saving clause validates all three surcharges; the Blues Conference argues that it preserves the 13% and 11% surcharges; and the State invokes it only as to the 11% surcharge. Although both the DOL and the Conference claim that HMOs are insurers for purposes of the saving clause, only the DOL contends that the 9% assessment on HMOs comes within ERISA's saving clause. The DOL argues that HMOs are engaged in the "business of insurance" when they reimburse hospitals for providing services to their subscribers. While HMOs must comply with certain provisions of the insurance law by virtue of the public health law, *see, e.g.*, N.Y. Pub. Health Law §§ 4402(2)(f) and 4406(1) (McKinney 1985) (superintendent of insurance required to review HMO subscriber contracts); N.Y. Pub. Health Law § 4409(2) (McKinney 1985) (superintendent required to examine each HMO's financial affairs periodically), New York law does not require HMOs to be state-licensed insurers. N.Y. Ins. Law § 1109(a)

(Footnote continued)

that these surcharges are not specifically directed toward the insurance industry; rather, they aim to regulate hospital rates. Although the surcharge laws provide for different payment rates based on whether a patient is uninsured, covered by an HMO, a commercial insurer or a self-insured health plan, they do not address matters typically within the purview of state insurance regulations such as: the solvency and qualification of an insurance company's management, the sale and advertising of insurance, rates and the content of insurance policies. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 727-28 & n.2 (1985).

Defendants argue that the 13% and 11% surcharges are designed to affect the insurance marketplace by giving the Blues a competitive advantage over commercial insurers, self-insured funds, and a number of other players in the marketplace — and thus may be characterized as the regulation of insurance. This argument, however, confuses laws regulating the "business of insurance" with laws regulating hospital rates that have an effect on the "insurance marketplace." Although the surcharge laws clearly have some impact on insurance companies, this alone is not enough. As the Supreme Court has made clear in interpreting § 2(b) of the McCarran-Ferguson Act, there is a difference between the "business of insurance" and the "business of insurers." *See Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 210-17 (1979).

In our view, defendants' arguments proceed from an impermissibly broad reading of the saving clause. Congress intended that ERISA's preemption provision would clear the field of any state law interfering with benefit plans, *see, e.g., FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990); *Pilot Life*, 481 U.S. at 47-48,

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(McKinney 1985 & Supp. 1993). Nor can HMOs include in their names "words generally regarded as descriptive of the insurance function." N.Y. Pub. Health Law § 4411 (McKinney 1985). These latter provisions support the district court's finding that the 9% assessment does not "fall within the scope of the savings clause because HMOs . . . do not engage in the 'business of insurance' as a matter of law." 813 F. Supp. at 1007.

and installed the saving clause to preserve only those state laws precisely directed at the insurance business. The more expansively the saving clause is read, the more deeply it cuts into the preemption, a result that would render the entire scheme unworkable.

Nor do the McCarran-Ferguson factors suggest otherwise. The Blues — unlike commercial carriers — offer health insurance to anybody, no matter who they are or what physical shape they are in. As the insurer of last resort, the Blues insure persons and groups that are, on the whole, older and less healthy, and therefore constitute unacceptably high risks for other insurers. Most high risk policyholders, therefore, are insured under the Blues. Because the 13% and 11% surcharges are designed to encourage ERISA plans — with generally healthier persons — to shift to the Blues, the State's reimbursement system would help spread the risk of health care costs.

Group Life & Health Insurance Co. v. Royal Drug Co., 440 U.S. 205 (1979), does not alter this conclusion. There, the Supreme Court ruled that Blue Shield's arrangement with certain pharmacies to charge Blue Shield's insureds only $2 for every prescription drug did not constitute the "business of insurance" under McCarran-Ferguson. As noted by the district court here, "[t]he Supreme Court held that the agreements between Blue Shield and the participating pharmacies did not spread any risk because those agreements merely reduced Blue Shield's costs for fulfilling an obligation which Blue Shield had already assumed." 813 F. Supp. at 1008 n.15 (citing *Royal Drug*, 440 U.S. at 212-14). Here, the challenged surcharges do not merely raise the cost of inpatient hospital services, but play a significant role in encouraging ERISA plans to shift to the Blues. Thus, unlike *Royal Drug*, the surcharges here can be said to have "the effect of transferring or spreading a policyholder's risk." *Pilot Life*, 481 U.S. at 48 (quoting *Union Labor Life Ins.*, 458 U.S. at 129).

The 13% and 11% surcharges, however, fail to satisfy the remaining two McCarran-Ferguson factors. These surcharges do not regulate any practice that is integral to the insurer-insured relationship. As we noted on an earlier occasion, the essence of

the second McCarran-Ferguson factor is whether a statute "dictate[s] any of the terms of the insurance contract itself, the principal embodiment of the insurer-insured relationship." *Howard*, 901 F.2d at 1159. True, the surcharges here were designed to induce ERISA plans to switch their hospital coverage from commercial insurers to the Blues; but they do not directly change any of the terms, conditions or scope of coverage in commercial insurance contracts. Rather, because the surcharges expressly regulate hospital rates, they relate only to the contractual obligations between hospitals and insurers or insureds, but do not directly implicate the policy relationship between insurers and their insureds.

Finally, the surcharges are not "limited to entities within the insurance industry." *Pilot Life*, 481 U.S. at 49 (quoting *Union Labor Life Ins.*, 458 U.S. at 129). In *Howard*, a provision of the New York Insurance Law required that either the insurer or the employer (in certain circumstances) give notice of conversion privileges upon termination of employment. *Id.* at 1156. We found that this provision was not a regulation of insurance. *Id.* at 1159. We noted that since the notice could be given by either the employer or the insurer, the law was not limited to entities within the insurance industry. *Id.* Here, the surcharges set rates that hospitals must charge patients, and thus involve entities beyond the insurance industry, including: the State, hospitals, patients, HMOs, and self-insured funds. Thus, the third McCarron-Ferguson factor is not satisfied.

Accordingly, because of our common-sense determination that the surcharges do not regulate insurance, and because two of the three McCarran-Ferguson factors are not satisfied, we agree with the district court that the 13% and 11% surcharges are not preserved by the saving clause. Accordingly, the New York statutes imposing the surcharges are preempted by ERISA.[6]

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[6] We also agree with the district court that the 9% assessment does not "fall within the scope of the savings clause because HMOs . . . do not engage in the 'business of insurance' as a matter of law," 813 F. Supp. at 1007, and is thus preempted by ERISA. *See* discussion *supra* note 4.

C. *The Actuarial Letter*

Self-insured employee benefit plans and their employer sponsors, including the Sheridan Catheter Plan (on whose behalf Travelers challenges the Actuarial Letter), often purchase stop-loss insurance to protect themselves against excess or catastrophic losses. Unlike traditional group-health insurance, stop-loss insurance is akin to reinsurance in that it does not provide coverage directly to plan members or beneficiaries. Rather, most stop-loss policies (and the policy issued to the Sheridan Catheter Plan here) provide coverage to the plan itself if the total amount of claims paid by the plan exceeds the amount of anticipated claims by a specified sum.

The Actuarial Letter under attack purports to regulate the terms of such stop-loss insurance contracts. Its relevant provisions follow:

> 1. The insurer must undertake to ensure that statutorily mandated benefits be covered under the employer's plan;
>
> 2. The insurer must agree to ensure that statutory conversion policies be provided, either by them or by another insurer;
>
> 3. Notice must be given to employees if and when the insurer becomes liable for runoff claims. . . .
>
> 4. The insurer should maintain full runoff reserves. If the policyholder holds his own reserves, the insurer's claim reserves are to be replaced by a terminal premium payable immediately upon termination. . . .
>
> 5. The insurer must take full responsibility for the payment of all employer plan claims incurred but not yet paid at the date of termination of the policy . . .

The district court properly found that ¶¶ 1, 2, 3, and 5 of the Actuarial Letter "relate to" an employee benefit plan for

purposes of ERISA's preemption clause. Paragraphs 1 and 5 on their face make specific "reference to" an employee benefit plan, and ¶¶ 2 and 3 clearly have a "connection with" such plans. *See Greater Wash. Bd. of Trade*, 113 S. Ct. at 583 (quoting *Shaw*, 463 U.S. at 97). ERISA therefore preempts ¶¶ 1, 2, 3, and 5 of the Actuarial Letter unless they find salvation in ERISA's saving clause as a law that regulates insurance, and even that salvation will be denied unless the employee benefit plan can escape the orbit of § 1144(b)(2)(B) refusing to deem such a plan "to be an insurance company or other insurer."

The district court concluded that ¶¶ 1, 2, 3, and 5 were preempted and the saving clause for insurance regulations did not save them because, under the deemer clause, self-insured employee benefit plans are not deemed to be "an insurance company or other insurer . . . ." *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990). The Department of Labor and Travelers, while agreeing with this result, suggest that the district court should not have reached the deemer clause without first considering whether ¶¶ 1, 2, 3, and 5 regulate insurance at all, within the meaning of the saving clause. We agree. Accordingly, we affirm the district court's holding on a different ground: ¶¶ 1, 2, 3, and 5 are not saved from preemption because those paragraphs do not regulate insurance within the meaning of the saving clause.

As already discussed, in order to fall within the saving clause, the state law must constitute the regulation of insurance from a common-sense point of view and must also satisfy the McCarran-Ferguson factors. *See Pilot Life*, 481 U.S. at 48-49. The challenged provisions of the Actuarial Letter do neither.

Pilot Life's common-sense test does not validate every conceivable restriction on the sale of insurance contracts under the rubric of regulation of insurance. *See Howard*, 901 F.2d at 1158. We conclude that ¶¶ 1, 2, 3, and 5 of the Actuarial Letter use the regulation of stop-loss coverage as a pretext to regulate the terms of self-funded ERISA plans.

In ¶ 1 of the Actuarial Letter, the State permits a self-insured plan to obtain stop-loss coverage only if the plan provides its

members and beneficiaries with the full panoply of benefits mandated by New York's Insurance Law. Paragraph 2 requires the plan to provide its beneficiaries with the right to a statutory conversion policy. Paragraphs 3 and 5 require the plan to afford its members a host of protections in case the plan becomes insolvent. Because the conditions imposed by the Actuarial Letter are not limited just to the stop-loss layer of insurance but apply generally to the entire plan, we conclude that ¶¶ 1, 2, 3, and 5 of the Letter do not, as a practical matter, regulate just insurance.

Furthermore, the challenged provisions of the Actuarial Letter do not satisfy the McCarran-Ferguson criteria. First of all, ¶¶ 1, 2, 3, and 5 do not have the effect of transferring or spreading risk between a self-funded plan and its stop-loss insurer but, instead, require the self-insured plan to provide additional benefits and protections to the plan's members and beneficiaries.

Second, the challenged provisions are not an integral part of a self-funded plan's relationship with its stop-loss insurer. Paragraph 1, for example, focuses squarely on the self-funded plan's relationship with its participants, not with the stop-loss insurer. Because employees are not insured under the terms of the stop-loss policy, requiring the stop-loss insurer to notify such individuals, as ¶ 3 does, is not an integral part of the insurance relationship. Likewise, because ¶ 5's purpose is to protect employees, who are not insured under the stop-loss contract, that paragraph is not an integral part of the insurance relationship between the plan and its stop-loss insurer.

Finally, ¶¶ 1, 2, 3, and 5 are not limited to insurance entities. Paragraph 1 is aimed directly at sponsors of self-funded plans. By requiring the sponsoring employer to provide conversion rights through another insurer if the stop-loss insurer does not provide such rights, ¶ 2 is aimed directly at employers who are not part of the insurance industry. *See Howard*, 901 F.2d at 1159 (state law requiring either insurer or employer to notify covered employees of conversion rights was not "limited to entities within

the insurance industry"). Likewise, ¶ 3 states specifically that the Department of Insurance "will accept a policy provision which requires the employer to pass along [the notice] material." Thus, it too is not "limited to entities within the insurance industry." *See id.*

In sum, the challenged provisions of the Actuarial Letter satisfy neither the common-sense test nor the McCarran-Ferguson factors. Consequently, they do not fall within the saving clause and are preempted.

The district court also held that ¶¶ 4, 6, and 7 of the Actuarial Letter do not "relate to" ERISA plans and, accordingly, did not reach the saving clause argument as to those paragraphs. On cross-appeal, Travelers argues that the district court erred to the extent it found that ¶ 4 does not "relate to" ERISA plans.[7] We agree and therefore reverse that part of the district court's decision holding that ¶ 4 is not preempted.

Paragraph 4, like ¶¶ 1, 2, 3, and 5 of the Actuarial Letter, is directed at the purchasers of stop-loss coverage which are primarily ERISA plans. It effectively requires the "policyholder" — which is an ERISA plan — either to purchase insurance for "run-off claims" or maintain significant reserves of its own. This alone merits a finding that ¶ 4 has a "connection with" employee benefit plans and, therefore, is "relate[d] to" such plans for purposes of ERISA's preemption clause because stop-loss protection will guarantee that benefits are paid to employees even if the carrier suffers catastrophic losses.

Reaching the saving clause argument, we conclude that ¶ 4 does not "regulate insurance" and therefore is not saved from ERISA preemption. In our view, ¶ 4 attempts to regulate, through the self-loss insurer, the benefits offered by and the administrative functioning of self-funded ERISA plans. Paragraph 4 is similar to the other challenged paragraphs. Like ¶¶ 1, 2,

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[7] The district court's findings as to ¶¶ 6 and 7 are not now challenged by Travelers or the Department of Labor.

3, and 5 of the Actuarial Letter, ¶ 4 does not fall within the saving clause and is, therefore, preempted.

We hold, therefore, that the five challenged paragraphs do not regulate insurance within the meaning of the saving clause and, accordingly, are preempted. We affirm the district court's ruling as to ¶¶ 1, 2, 3, and 5 of the Actuarial Letter, and reverse as to ¶ 4.

CONCLUSION

To sum up: We find that the district court properly found that plaintiffs' challenges to the 11% and 9% surcharges are not barred by the TIA. Nor is their challenge to the 13% differential barred by laches. Further, the district court properly held that the three surcharges are preempted by ERISA, and the 13% and 11% surcharges are also preempted by FEHBA. Finally, we affirm the court's decision as to ¶¶ 1, 2, 3, and 5 of the Actuarial Letter, and reverse as to ¶ 4.

Accordingly, the judgment of the district court is affirmed in part, reversed in part, and the district court is directed to enter judgment consistent with this opinion.

UNITED STATES COURT OF APPEALS

FOR THE SECOND CIRCUIT

Nos. 1514, 1515, 1516, 1667—August Term, 1992

(Argued: May 20, 1993 Decided: October 25, 1993)

Docket Nos. 93-7132L, 93-7134CON,
93-7148CON, 93-7194XAP

THE TRAVELERS INSURANCE COMPANY,

Plaintiff-Appellee-Cross-Appellant,

HEALTH INSURANCE ASSOCIATION OF AMERICA, AMERICAN COUNCIL OF LIFE INSURANCE, LIFE INSURANCE COUNCIL OF NEW YORK, INC., AETNA LIFE INSURANCE CO., AETNA HEALTH PLANS OF NEW YORK, INC., MUTUAL OF OMAHA INSURANCE COMPANY, THE UNION LABOR LIFE INSURANCE COMPANY, PROFESSIONAL INSURANCE AGENTS OF NEW YORK, INC. TRUST,

Plaintiffs-Appellees,

NEW YORK STATE HEALTH MAINTENANCE ORGANIZATION CONFERENCE AND HEALTH SERVICES MEDICAL CORPORATION, MVP HEALTH PLAN, WELLCARE OF NEW YORK, MID-HUDSON HEALTH PLAN, OXFORD HEALTH PLAN, CAPITAL DISTRICT PHYSICIANS HEALTH PLAN, CHOICECARE LONG ISLAND, INDEPENDENT HEALTH, TRAVELERS OF NEW YORK, PHYSICIANS HEALTH SERVICES, PREFERRED CARE and U.S. HEALTHCARE,

Plaintiffs-Intervenors-Appellees,

—v.—

MARIO M. CUOMO, in his official capacity as Governor of the State of New York, MARK CHASSIN, M.D., in his official capacity as Commissioner of Health for the State of New York, SALVATORE R. CURIALE, in his official capacity as Superintendent of Insurance of the State of New York, MARY JO BANE, in her official capacity as Commissioner of Social Services of the State of New York, Robert Abrams, in his official capacity as Attorney General of the State of New York,

Defendants-Appellants-Cross-Appellees,

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, EMPIRE BLUE CROSS AND BLUE SHIELD, HOSPITAL ASSOCIATION OF NEW YORK STATE,

Intervenors-Defendants-Appellants-Cross-Appellees.

B e f o r e:

LUMBARD, CARDAMONE, and McLAUGHLIN,
Circuit Judges.

Appeal and cross-appeal from a judgment of the United States District Court for the Southern District of New York (Louis J. Freeh, *Judge*), granting plaintiffs' motions for summary judgment in part and denying defendants' motions and cross-motions for summary judgment. The district court held, *inter alia*, that: (1) certain provisions of New York Public Health Law § 2807-c are preempted by ERISA, 29 U.S.C. §§ 1001-1461, and FEHBA, 5 U.S.C. §§ 8901-8914; and (2) ERISA also preempts parts of Actuarial Letter No. 5, issued by New York's Department of Insurance.

Affirmed in part; reversed in part.

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Omaha Insurance Company, The Union Labor Life Insurance Company, Aetna Life Insurance Company and Aetna Health Plans of New York, Inc. and Professional Insurance Agents of New York, Inc. Trust.

HAROLD N. ISELIN, Albany, NY (Barbara S. Brenner, Steve T. Engelman, Couch, White, Brenner, Howard & Feigenbaum, Albany, NY, of counsel), *for Plaintiffs-Intervenors-Appellees New York State Health Maintenance Organization Conference, Capital District Physicians' Health Plan, Inc., Choicecare Long Island, Inc., Health Services Medical Corporation of Central New York, Inc., Independent Health Association, Inc., Mid-Hudson Health Plan, Inc., Mohawk Valley Physicians' Health Plan, Inc., Oxford Health Plans, Inc., Physicians Health Services of New York, Inc., Preferred Care, Inc., Travelers Health Network of New York, Inc., U.S. Healthcare, Inc., and Wellcare of New York, Inc.*

Stuart E. Schiffer, Acting Ass't Attorney General, Washington, DC (Roger S. Hayes, U.S. Attorney, Anthony J. Steinmeyer, Scott R. McIntosh, Appellate Staff, Civil Division, Dep't of Justice, Washington, DC, of counsel), *filed a brief on behalf of the United States as Amicus Curiae.*

Susan M. Green, Trial Attorney, U.S. Dep't of Labor, Washington, DC (Judith E. Kramer, Deputy Solicitor of Labor, Marc I. Machiz, Associate Solicitor, Plan

Benefits Security Division, Karen L. Handorf, Counsel for Decentralized and Special Litigation, Eric G. Serron, Trial Attorney, U.S. Dep't of Labor, Washington, DC, of counsel), *filed a brief on behalf of the Secretary of Labor as Amicus Curiae.*

Hugh Barber, Ass't Attorney General, Hartford, CT (Richard Blumenthal, Attorney General of the State of Connecticut, Richard J. Lynch, Arnold I. Menchel, Paul J. Lahey, Phyllis E. Hyman, Ass't Attorneys General, Hartford, CT, of counsel), *filed a brief on behalf of the State of Connecticut as Amicus Curiae.*

Benjamin W. Boley, Washington, DC (William H. Dempsey, Shea & Gardner, Washington, DC, of counsel), *filed a brief on behalf of the National Carriers' Conference Committee as Amicus Curiae.*

Edward J. Groarke, Garden City, NY (Colleran, O'Hara & Mills, of counsel), *filed a brief on behalf of Trustees of and The Pension, Hospitalization Benefit Plan of the Electrical Industry and Trustees of and United Food and Commercial Workers Local 174 Health Care Fund, Trustees of and United Food and Commercial Workers Local 174 Retail Welfare Fund, and Trustees of and United Food and Commercial Workers Local 174 Commercial Health Care Fund as Amici Curiae.*

McLAUGHLIN, *Circuit Judge*:

Defendants Mario Cuomo *et al.* ("the State") and intervenors-defendants New York Conference of Blue Cross and Blue Shield Plans *et al.* appeal from a judgment of the United States District Court for the Southern District of New York (Louis J. Freeh, *Judge*), granting plaintiffs' motions for summary judgment in part and denying defendants' motions and cross-motions for summary judgment. *Travelers Ins. Co. v. Cuomo*, 813 F. Supp. 996 (S.D.N.Y. 1993).

The district court held that certain components of New York's inpatient hospital reimbursement system are preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001-1461 (1988 & Supp. IV 1992), and the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. §§ 8901-8914 (1988 & Supp. IV 1992). In particular, the district court invalidated three subsections of New York Public Health Law § 2807-c (McKinney Supp. 1993) imposing surcharges on the hospital rates for certain categories of payors, and not others. The district court also held that ERISA preempts ¶¶ 1, 2, 3, and 5 of Actuarial Letter No. 5, issued by New York's Department of Insurance.

The Travelers Insurance Company ("Travelers") cross-appeals, contending that the district court should also have granted its motion for summary judgment as to ¶ 4 of the Actuarial Letter, as well. We agree with Travelers and reverse that portion of the judgment which held that ¶ 4 is not preempted by ERISA. In all other respects, we affirm.

BACKGROUND

Eighty-eight percent of non-elderly Americans have private health care insurance through their employee welfare benefit plans. ERISA is the governing statute. ERISA plans provide health coverage to employees in various ways, including: (1) the purchase of commercial health insurance from an insurer; (2) self-insurance, whereby the plan is directly responsible for health care bills and usually carries excess liability coverage known as

"stop-loss" coverage; (3) subscription to a health maintenance organization ("HMO"); and (4) coverage through non-profit health service corporations, such as Blue Cross/Blue Shield plans (the "Blues").

Any patient entering a hospital is placed in a category known as a diagnosis-related group ("DRG"), based on his symptoms and probable cost of treatment. The amount the hospital may charge for the patient's care is based on the DRG, not the actual cost of treatment. New York law provides that the DRG amount charged to a particular patient is then increased by a "payor factor," depending on the type of health care coverage the patient has. This, of course, results in a "differential" in the charges, depending on which type of health care coverage the patient has.

Since its enactment in 1988, New York Public Health Law § 2807-c(1)(b) has required that insurance carriers of patients covered by any form of health plan other than the Blues, an HMO, or government insurance such as Medicaid must pay 13% above the DRG rate. The 13% differential, which is kept by the hospital, was enacted to contain hospital costs and to increase the availability of hospital insurance coverage to needy New Yorkers. In particular, the differential was meant to " 'level [the] playing field' " for the Blues "in their competition with commercial insurers." Joint Appendix at 649; Clyne Aff. ¶ 15. The hope was that this would encourage more employers and ERISA plans to subscribe to the Blues.

The New York Omnibus Revenue Act of 1992 imposed two more surcharges: (1) an additional 11% surcharge on DRG payment rates charged to patients covered by commercial insurance, 1992 N.Y. Laws, ch. 55, § 348 (codified as amended at N.Y. Pub. Health Law § 2807-c(11)(i) (McKinney Supp. 1993)); and (2) an assessment of up to 9% on HMOs which fail to enroll a target number of Medicaid-eligible persons. 1992 N.Y. Laws, ch. 55, § 346 (codified as amended at N.Y. Pub. Health Law § 2807-c(2-a)(a) (McKinney Supp. 1993)). Unlike the basic 13% differential, the proceeds of the 11% surcharge are not kept by

the hospital, but are paid into a statewide pool, which is then deposited into the State's general fund. HMOs, in contrast, must pay their 9% assessment directly into a statewide HMO pool, but it too ultimately winds up in the State's coffers.

The obvious effect of the 11% surcharge is to increase commercial insurers' costs of providing health care, thus making them less competitive with the Blues. Unlike the 11% surcharge, however, the primary purpose of the 9% assessment is to encourage HMOs to enroll Medicaid recipients, thereby lowering the costs of the Medicaid program.

Besides imposing surcharges, New York's Department of Insurance has issued "Actuarial Information Letter No. 5," regulating how self-insured plans obtain "stop-loss" insurance. The Letter: (1) permits a self-insured to obtain stop-loss insurance only if the plan provides its members with statutorily mandated services; (2) requires that self-insured plans provide beneficiaries with the right to a statutory conversion policy; and (3) requires self-insured plans to afford members various protections in case the plan becomes insolvent.

In separate actions, several commercial insurers and insurance industry trade associations, including Travelers and the Health Insurance Association of America ("HIAA"), sued various New York State authorities for declaratory and injunctive relief, complaining that all three surcharges and the Actuarial Letter are preempted by ERISA, and the 13% and 11% surcharges are also preempted by FEHBA. The New York State Conference of Blue Cross and Blue Shield Plans, Empire Blue Cross and Blue Shield (collectively, the "Blues Conference"), and the Hospital Association of New York State ("HANYS") intervened as defendants; the New York State Health Maintenance Organization Conference and several HMOs intervened as plaintiffs. Thereafter, the parties cross-moved for summary judgment, and the district judge then consolidated the various actions.

The district court granted most of the relief that plaintiffs sought, holding that: (1) the Tax Injunction Act does not preclude an injunction against the 11% and 9% surcharges; (2) ERISA

preempts all three surcharges; (3) FEHBA preempts the 13% and 11% surcharges; (4) plaintiffs' claims as to the 13% surcharge are not barred by the doctrine of laches; and (5) ¶¶ 1, 2, 3, and 5 of the Actuarial Letter are also preempted by ERISA. The court enjoined the defendants from enforcing the surcharges and the Actuarial Letter against the appropriate payors, but then stayed its ruling insofar as it enjoined the State from enforcing the 13% surcharge. Defendants appeal and plaintiff Travelers cross-appeals.

DISCUSSION

To promote clarity, we divide our analysis into three segments: (1) whether the district court had jurisdiction over these actions; (2) whether the equitable defense of laches raised by intervenor HANYS has merit; and (3) finally, we address the chief argument advanced in support of reversal, ERISA preemption.

I. *Jurisdiction*

The Tax Injunction Act ("TIA") provides that federal district courts "shall not enjoin, suspend, or restrain the assessment . . . of any tax under State law where a plain, speedy and efficient remedy may be had in the courts of such State." 28 U.S.C. § 1341 (1988); *see Kraebel v. New York City Dep't of Hous. Preservation & Dev.*, 959 F.2d 395, 400 (2d Cir.) (TIA "bars federal injunctive challenges to state tax laws in federal courts."), *cert. denied*, 113 S. Ct. 326 (1992). This prohibition includes "declaratory as well as injunctive relief." *Barringer v. Griffes*, 964 F.2d 1278, 1280 (2d Cir. 1992).

The district court held that the TIA did not apply to the 11% and 9% surcharges, and therefore, it had jurisdiction. Two conditions must be satisfied to invoke the protection of the TIA: first, the surcharges must constitute "taxes,"[1] and second, the state remedies available to plaintiffs must be "plain, speedy and efficient." *See Kraebel*, 959 F. 2d at 400.

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[1] The Blues Conference does not argue that the 13% differential is a "tax" for good reason: its proceeds are retained by the hospitals and not deposited into the State treasury.

A. *Taxes*

The district court "assumed" that the 11% and 9% surcharges were "taxes" under the TIA, stating "to the extent that [these] [s]urcharges are paid into New York's General Fund, they appear to be taxes." 813 F. Supp. at 1000 & n.1 (citation omitted). Although there is no bright line between assessments that are taxes and those that are not, most courts agree that "[a]ssessments which are imposed primarily for revenue-raising purposes are 'taxes,' while levies assessed for regulatory or punitive purposes, even though they may also raise revenues, are generally not 'taxes.' " *Butler v. Maine Supreme Judicial Court*, 767 F. Supp. 17, 19 (D. Me. 1991) (collecting cases). In general, courts "have tended . . . to emphasize the revenue's ultimate use, asking whether it provides a general benefit to the public, of a sort often financed by a general tax, or whether it provides more narrow benefits to regulated companies or defrays the agency's costs of regulation." *San Juan Cellular Tel. Co. v. Public Serv. Comm'n*, 967 F.2d 683, 685 (1st Cir. 1992).

It is apparent that the 11% and 9% surcharges are taxes. Notwithstanding the primary purposes ascribed to the surcharges by the State, both raise revenue which is ultimately paid into the State's general fund. Thus, because the contested surcharges serve general revenue-raising purposes, they constitute "taxes" for purposes of the TIA. *See, e.g., Keleher v. New England Tel. & Tel. Co.*, 947 F.2d 547, 549 (2d Cir. 1991) (the word "tax" under the TIA "encompasses any state or local revenue collection device," including a city-assessed public utility "franchise fee" because the money raised was treated as part of the city's "general revenue"); *Butler*, 767 F. Supp. at 19 (nonrefundable jury fee required in Maine state courts "fits comfortably within [the] definition of a 'tax' under section 1341" because "the fees collected will be funneled into Maine's general fund, rather than being applied directly to the costs of jury trials.").

B. *State Remedy*

The district court found that plaintiffs did not have a "plain, speedy and efficient remedy" in New York state court "[b]ecause

ERISA generally confers exclusive jurisdiction on the federal courts." 813 F. Supp. at 1001 (relying upon *National Carriers' Conference Comm. v. Heffernan*, 440 F. Supp. 1280, 1283 (D. Conn. 1977)). Plaintiffs sued here as plan fiduciaries to enjoin a practice violating ERISA. Congress has divested the state courts of jurisdiction over such claims. *See* 29 U.S.C. § 1132(e)(1) (1988); *see also Shofer v. Hack Co.*, 970 F.2d 1316, 1319 (4th Cir. 1992) (where ERISA claims are within the exclusive jurisdiction of the federal courts, state courts are plainly without jurisdiction). Thus, "[b]ecause the [New York] courts lack the jurisdiction to decide the plaintiffs' injunctive and declaratory ERISA claims, the plaintiffs are without a 'plain, speedy and efficient' remedy at state law." *Thiokol Corp. v. Department of Treasury, Revenue Div.*, 987 F.2d 376, 380 (6th Cir. 1993); *accord E-Systems, Inc. v. Pogue*, 929 F.2d 1100, 1102 (5th Cir.) (TIA is "inapplicable" in an ERISA setting), *cert. denied*, 112 S. Ct. 585 (1991).

Accordingly, we conclude that the district court did not err in finding that the state remedies available to plaintiffs were inadequate, and thus it had jurisdiction over plaintiffs' claims.

II. *Laches*

New York's complex reimbursement system has had a differential among various payors since the late 1970s. A statutory differential has existed since 1983. Hence, intervenor HANYS contends that plaintiffs' current challenge to the 13% differential is barred by laches.

Laches is an equitable defense that applies when "a plaintiff unreasonably delayed in initiating an action and a defendant was prejudiced by the delay." *Robins Island Preservation Fund, Inc. v. Southold Dev. Corp.*, 959 F.2d 409, 423 (2d Cir.) (citations omitted), *cert. denied*, 113 S. Ct. 603 (1992). We review a district court's application of the laches doctrine for an abuse of discretion, *see King v. Innovation Books, Div. of Innovative Corp.*, 976 F.2d 824, 832 (2d Cir. 1992), and we find no abuse here.

In our view, there was a legitimate reason for plaintiffs' delay in mounting this challenge. *See Stone v. Williams*, 873 F.2d 620,

624 (2d. Cir.) ("[I]t is the reasonableness of the delay rather than the number of years that elapsed which is the focus of the [laches] inquiry."), *cert. denied*, 493 U.S. 959, *and vacated on other grounds*, 891 F.2d 401 (2d Cir. 1989), *cert. denied*, 496 U.S. 937 (1990). Almost ten years ago, in *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985), we rejected a claim that ERISA preempted New York's regulatory scheme governing hospital rates.

Rebaldo, while probably distinguishable, created little hope for the success of future challenges to New York's reimbursement system. Prospects of success improved only recently because of Supreme Court cases which, as will be discussed *infra*, undermine *Rebaldo*. Immediately after *Rebaldo*, instead of challenging the 13% differential in court, plaintiffs changed their tactics and sought a legislative remedy, instead. Only when these legislative efforts failed in 1992 with the enactment of an additional 11% surcharge did they sue the State. This is not a tableau of unreasonable delay. Accordingly, we find no error in the district court's rejection of the laches defense.

III. *ERISA Preemption*

Whether a particular state statute is preempted by ERISA is a question of statutory interpretation, as informed by congressional intent. With understated irony, the Supreme Court has described the ERISA section at issue here as "not a model of legislative drafting." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985). In truth, it is a veritable Sargasso Sea of obfuscation:

> **(a) Supersedure; effective date**
>
> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter *relate to* any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. . . .

(b) Construction and application

. . . .

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which *regulates insurance*, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be *deemed* to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

29 U.S.C. § 1144(a)-(b)(2)(B) (1988) (emphasis added).

The opening paragraph is the *preemption* clause. The next paragraph [(b)(2)(A)] is the *saving* clause. And the final paragraph [(b)(2)(B)] has come to be known as the *deemer* clause. *See FMC Corp. v. Holliday*, 498 U.S. 52, 57-58 (1990).

Setting sail, we begin with the observation that ERISA is a comprehensive federal statutory scheme regulating "private employee benefits plans, including both pension and welfare plans." *District of Columbia v. Greater Wash. Bd. of Trade*, 113 S. Ct. 580, 582 (1992). "A 'welfare plan' is defined . . . to include, *inter alia*, any 'plan, fund, or program' maintained for the purpose of providing medical or other health benefits for employees or their beneficiaries 'through the purchase of insurance or otherwise.' " *Id.* (quoting 29 U.S.C. § 1002(1)). While the statute does not mandate particular benefits, it " 'sets various uniform standards, including rules concerning reporting, disclosure, and fiduciary responsibility, for . . . welfare plans.' "

Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 137 (1990) (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 91 (1983) (citation omitted)).

ERISA expressly preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by the statute. 29 U.S.C. § 1144(a) (the preemption clause). This sweeping provision is not without qualification and, pertinent to this case, excepts from preemption those state laws that "regulate insurance," 29 U.S.C. § 1144(b)(2)(A) (the saving clause), except as further provided in the deemer clause, stating that an employee benefit plan governed by ERISA shall not be "deemed" an insurance company, an insurer, or "engaged in the business of insurance . . . for purposes of any [state law] purporting to regulate" insurance companies or insurance contracts. 29 U.S.C. § 1144(b)(2)(B); *see FMC Corp.*, 498 U.S. at 58.

The district court concluded that all the surcharges, as well as ¶¶ 1, 2, 3, and 5 of the Actuarial Letter "relate to" employee benefit plans within the meaning of ERISA's preemption clause. The court also found that the surcharges are not preserved by the saving clause as laws that "regulate insurance;" and, without considering whether the Actuarial Letter regulates insurance, the court also concluded that the deemer clause precluded any state regulation of self-funded plans. Accordingly, the district court held that ERISA preempted the three surcharges and also ¶¶ 1, 2, 3, and 5 of the Actuarial Letter. For the reasons set forth below, we substantially agree.

The Supreme Court has "repeatedly stated that a law 'relate[s] to' a covered employee benefit plan for purposes of [the preemption clause] 'if it has a connection with or reference to such a plan.' " *Greater Wash. Bd. of Trade*, 113 S. Ct. at 583 (quoting *Shaw*, 463 U.S. at 97) (citations omitted). The term "relate to" is to be accorded "its broad common-sense meaning," *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47 (1987), thereby giving "effect to the 'deliberately expansive' language chosen by Congress." *Greater Wash. Bd. of Trade*, 113 S. Ct. at 583 (quoting *Pilot Life*, 481 U.S. at 46). "Under this 'broad common-sense meaning,' a state law may 'relate to' a benefit plan, and thereby be

pre-empted, even if the law is not specifically designed to affect such plans or the effect is only indirect," *Ingersoll-Rand*, 498 U.S. at 139, and even if the law is "consistent with ERISA's substantive requirements." *Metropolitan Life Ins.*, 471 U.S. at 739. Accordingly, we have held that "a state law of general application, with only an indirect effect on a pension plan, may nevertheless be considered to 'relate to' that plan for preemption purposes." *Smith v. Dunham-Bush, Inc.*, 959 F.2d 6, 9 (2d Cir. 1992).

On the other hand, the Court has also recognized that "[s]ome state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan," *Shaw v. Delta Air Lines, Inc.*, 463 U.S. at 100 n.21 (1983), "as is the case with many laws of general applicability." *Greater Wash. Bd. of Trade*, 113 S. Ct. at 583 n.1. *See, e.g., Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988) (generally applicable garnishment law under which creditors can garnish ERISA welfare benefits not preempted); *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987) (law requiring companies to make lump-sum severance payments when closing a plant not preempted); *Aetna Life Ins. Co. v. Borges*, 869 F.2d 142 (2d Cir.) (application of escheat law to ERISA-covered benefit checks and drafts issued but not collected or presented for payment by beneficiaries not preempted), *cert. denied*, 493 U.S. 811 (1989).

On appeal, defendants contend that "the [s]urcharges do not 'relate to' ERISA plans within the meaning of ERISA's preemption clause because they are laws of general application, which have only a peripheral impact on the plans." 813 F. Supp. at 1005. In making this argument, defendants rely on *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985) and fault the district court for its conclusion that *Rebaldo* "has been abrogated by later Supreme Court cases." 813 F. Supp. at 1005.

Rebaldo held that ERISA did not preempt certain New York regulations governing the right of self-insured employee benefit plans to negotiate discounts with hospitals. In rejecting this

challenge, we initially found that "a state law must '*purport*[] to regulate, . . . the terms and conditions of employee benefit plans' to fall within the preemption provision" of ERISA. *Rebaldo*, 749 F.2d at 137 (quoting 29 U.S.C. § 1144(c)(2)) (emphasis added). *Rebaldo* went on to hold that the impact of New York's regulations on ERISA benefit plans was too tenuous, remote, and peripheral to require preemption. *Id.* at 138. Six years later, in *Ingersoll-Rand*, 498 U.S. at 141, the Supreme Court expressly rejected the notion that Congress intended to limit ERISA's preemptive effect to state laws *purporting* to regulate plan terms and conditions. *See Smith*, 959 F.2d at 9 & n.3 (following *Ingersoll-Rand*, rejecting "purports to regulate" standard). Despite *Ingersoll-Rand*, defendants continue to argue that *Rebaldo*'s analysis of what triggers ERISA preemption is still controlling.

We have little difficulty agreeing with the district court that *Rebaldo*'s fundamental premise was rejected by the Supreme Court. In our view, *Rebaldo*'s entire analysis is poisoned by its discredited belief that ERISA's preemption clause is targeted only at state laws that "purport to regulate" plan terms and conditions. Therefore, we conclude that defendants' reliance on *Rebaldo* is misplaced.

A. *The Surcharges: Preemption*

Defendants maintain that the district court erred in concluding that the challenged statutes' indirect economic impact upon ERISA plans was substantial and impermissibly affected the structure, the administration, or the type of benefits furnished by a plan. We disagree. While the challenged statutes do not refer to ERISA plans, *see Mackey*, 486 U.S. at 831 (statute need not specifically mention ERISA plans to be preempted), our examination of the surcharges indicates that they satisfy the less stringent "connection with" standard embraced in *Ingersoll-Rand*.

The 13% and 11% surcharges are designed to increase hospital costs for patients covered by health plans other than the Blues, and thus make these competing plans less attractive than the

Blues. Obviously, the surcharges will affect ERISA plans' health care benefits. Likewise, the 9% assessment imposed on HMOs will interfere with a plan's selection of the most effective method to provide benefits. Thus, the surcharges purposely interfere with the choices that ERISA plans make for health care coverage. Such interference is sufficient to constitute "connection with" ERISA plans. *See, e.g., National Elevator Indus., Inc. v. Calhoon*, 957 F.2d 1555, 1561 (10th Cir.) (ERISA preempts administrative interpretation of Oklahoma's prevailing wage statute insofar as it determines rates of pay and "may be used to effect change in the administration, structure and benefits of an ERISA plan"), *cert. denied*, 113 S. Ct. 406 (1992); *In re Michigan Carpenters Council Health & Welfare Fund*, 933 F.2d 376, 382-83 (6th Cir.) (ERISA preempts Michigan state corporate reorganization statute that allows employers unilaterally to alter their obligation to ERISA plans), *cert. denied*, 112 S. Ct. 585 (1991); *National Carriers' Conference Comm. v. Heffernan*, 440 F. Supp. 1280 (D. Conn. 1977) (Connecticut tax on ERISA benefits preempted since it may encourage use of traditional insurance rather than ERISA-covered plans); *Morgan Guar. Trust Co. v. Tax Appeals Tribunal of Dep't of Taxation & Finance*, 80 N.Y.2d 44, 51, 587 N.Y.S.2d 252, 256, 599 N.E.2d 656, 660 (1992) (New York real estate gains tax preempted as applied to sale of ERISA property because tax will influence plans' investment strategy).

The surcharges substantially increase the cost to ERISA plans of providing beneficiaries with a given level of health care benefits. Under similar circumstances, the Fifth Circuit held that a state statute imposing a 2.5% tax on administrative and service fees was preempted by ERISA. *E-Systems, Inc. v. Pogue*, 929 F.2d 1100 (5th Cir.), *cert. denied*, 112 S. Ct. 585 (1991). The court found that the tax was related to ERISA plans because: "The cost of the plan must therefore increase for the employer and/or employees or the benefits must be adjusted downwards to offset the tax bite. This is the type of impact Congress intended to avoid when it enacted the ERISA legislation." *Id.* at 1103.

As in *E-Systems*, the surcharges here force ERISA plans to increase either plan costs or reduce plan benefits. Therefore, they

have the requisite connection to ERISA. *See also General Electric Co. v. New York State Dep't of Labor*, 891 F.2d 25, 28 (2d Cir. 1989) (New York Labor Law governing wage requirements was preempted where it required employers to pay certain benefits, because " 'private parties, not the Government, control the level of benefits' " under ERISA) (quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 511 (1981)), *cert. denied*, 496 U.S. 912 (1990); *cf. Arkansas Blue Cross & Blue Shield v. St. Mary's Hosp., Inc.*, 947 F.2d 1341, 1348 (8th Cir. 1991) ("Like all the factors considered, . . . simply because the existence of some economic impact is not dispositive of the preemption issue does not make this factor irrelevant to the preemption inquiry."), *cert. denied*, 112 S. Ct. 2305 (1992).

In making its finding that the surcharges are related to ERISA, the district court focused on plaintiffs' claims that they would pass along the higher costs associated with the surcharges, which might in turn lead plans to reduce their level of service or benefits. Defendants and the Department of Labor as *amicus* contend that the indirect and inevitably speculative economic impact of the challenged statutes *alone* does not justify a finding of preemption. They argue that the Supreme Court has never held that indirect economic impact, standing alone, is sufficient to justify a finding of preemption. *See, e.g., Mackey*, 486 U.S. at 830-41 (indirect economic effect of state garnishment law not enough to warrant preemption); *see also Aetna Life*, 869 F.2d at 146 ("where a state statute of general application 'does not affect the structure, the administration, or the type of benefits provided by an ERISA plan, the mere fact that the statute has some economic impact on the plan does not require that the statute be invalidated.' " (quoting *Rebaldo*, 749 F.2d at 139)).

The Blues Conference, in particular, relies on *NYSA-ILA Medical & Clinical Servs. Fund v. Axelrod*, No. 92 Civ. 2779 (JSM), 1993 WL 51146, at *4 (S.D.N.Y. Feb. 23, 1993) ("The tax is not great enough to pose a serious economic threat to the plan which might trigger preemption."). There, Judge Martin rejected an ERISA plan's challenge to New York's Health Facility Assessment ("HFA") because its economic impact on the plan was *de*

minimis. The court distinguished *Morgan Guaranty Trust*, 80 N.Y.2d 44, 587 N.Y.S.2d 252, 599 N.E.2d 656, on the ground that the New York case involved a "substantial" tax of 10% of the consideration received for the realty sold therein, as opposed to the HFA of 0.6% of gross receipts to which the HFA was applicable. Further, Judge Martin in *NYSA-ILA* explicitly compared the result Judge Freeh reached in this case, with its surcharges of 13%, 11%, and 9% on hospital DRGs. *See NYSA-ILA*, 1993 WL 51146, at *4. Thus, the *NYSA-ILA* court recognized that a *substantial* economic impact, standing alone, could be enough to bring ERISA's preemption clause into play.

In sum, Judge Freeh properly found that the three surcharges "relate to" ERISA because they impose a significant economic burden on commercial insurers and HMOs. They therefore have an impermissible impact on ERISA plan structure and administration.[2] Accordingly, the statutes at issue here are preempted – unless they are salvaged by ERISA's saving clause as a law that regulates insurance. 29 U.S.C. § 1144(b)(2)(A).

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[2] To the extent that our holding conflicts with *United Wire, Metal & Machine Health & Welfare Fund v. Morristown Memorial Hosp.*, 995 F.2d 1179 (3rd Cir. 1993), *petition for cert. filed*, 62 USLW 3061 (July 22, 1993)(No. 93-115), *and petition for cert. filed*, 62 USLW 3114 (Aug. 4, 1993)(No. 93-193), *and petition for cert. filed*, 62 USLW 3114 (Aug. 5, 1993)(No. 93-194), *and petition for cert. filed*, 62 USLW 3144 (Aug. 6, 1993)(No. 93-210), we decline to follow it. In that case, several self-insured union employee welfare benefit plans sued numerous New Jersey hospitals and various New Jersey State authorities for injunctive relief, complaining that New Jersey's statutory scheme for setting hospital rates was preempted by ERISA. The rate-setting statute at issue imposed additional surcharges on DRG rates to compensate hospitals for providing "uncompensated care" and treating Medicare patients, and granted discounts to certain classes of payors.

The Third Circuit held that the rate-setting statute "does not relate to the plans in a way that triggers ERISA's preemption clause." *Id.* at 1191. In brief, the court found that the connection between the statute and ERISA plans was too tenuous and remote "[b]ecause we are here dealing with a statute of general applicability that is designed to establish the prices to be paid for hospital services, which does not single out ERISA plans for special treatment, and which functions without regard to the existence of such plans," *id.* at 1192,

(Footnote continued)

B. *The Surcharges: Saving Clause*

To determine whether a state law regulates insurance within the meaning of the saving clause, a court must first "consider the 'common-sense view' of the term 'regulates insurance' which suggests that 'in order to regulate insurance, a law must not just have an impact on the insurance industry, but must be *specifically* directed toward that industry.'" *Howard v. Gleason Corp.*, 901 F.2d 1154, 1158 (2d Cir. 1990) (quoting *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50 (1987)). The court must next assess whether the law satisfies the three criteria developed for determining whether a practice constitutes "the business of insurance" within the meaning of the McCarran-Ferguson Act, 15 U.S.C. §§1011-1015 (1988 & Supp. IV 1992).[3] *See Pilot Life*, 481 U.S. at 48. Those criteria are: " '*First*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*,

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and the statute's "indirect ultimate effect of increasing plan costs" places it beyond the scope of ERISA preemption. *Id.* at 1193-95.

Ironically, in reaching its conclusion, the Third Circuit relied heavily on our opinion in *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985). As we discuss above, however, we believe that decisions of the Supreme Court since *Rebaldo* have significantly eroded the premise upon which *Rebaldo* was decided. More generally, however, we also believe that the Third Circuit reads ERISA's preemption clause too narrowly. *See United Wire*, 995 F.2d at 1196-1203 (Nygaard, J., dissenting).

[3] The McCarran Act was enacted in 1945 to help resolve federalism concerns over the roles of federal and state governments in regulating insurance. Now known as the McCarran-Ferguson Act, it provides, in relevant part:

> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided*, That [the Sherman Act, the Clayton Act, and the Federal Trade Commission Act] shall be applicable to the business of insurance to the extent that such business is not regulated by State Law.

15 U.S.C. § 1012(b).

whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry.' " *Id.* at 48-49 (quoting *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982)).

Applying these tests, we conclude, first of all, that the 13% and 11% surcharges do not "regulate insurance" within the meaning of the saving clause.[4] Our common-sense inquiry reveals that these surcharges are not specifically directed toward the insurance industry; rather, they aim to regulate hospital rates. Although the surcharge laws provide for different payment rates based on whether a patient is uninsured, covered by an HMO, a commercial insurer or a self-insured health plan, they do not address matters typically within the purview of state insurance regulations such as: the solvency and qualification of an insurance company's management, the sale and advertising of insurance, rates and the content of insurance policies. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 727-28 & n.2 (1985).

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[4] The Department of Labor ("DOL") argues that the saving clause validates all three surcharges; the Blues Conference argues that it preserves the 13% and 11% surcharges; and the State invokes it only as to the 11% surcharge. Although both the DOL and the Conference claim that HMOs are insurers for purposes of the saving clause, only the DOL contends that the 9% assessment on HMOs comes within ERISA's saving clause. The DOL argues that HMOs are engaged in the "business of insurance" when they reimburse hospitals for providing services to their subscribers. While HMOs must comply with certain provisions of the insurance law by virtue of the public health law, *see, e.g.*, N.Y. Pub. Health Law §§ 4402(2)(f) and 4406(1) (McKinney 1985) (superintendent of insurance required to review HMO subscriber contracts); N.Y. Pub. Health Law § 4409(2) (McKinney 1985) (superintendent required to examine each HMO's financial affairs periodically), New York law does not require HMOs to be state-licensed insurers. N.Y. Ins. Law § 1109(a) (McKinney 1985 & Supp. 1993). Nor can HMOs include in their names "words generally regarded as descriptive of the insurance function." N.Y. Pub. Health Law § 4411 (McKinney 1985). These latter provisions support the district court's finding that the 9% assessment does not "fall within the scope of the savings clause because HMOs . . . do not engage in the 'business of insurance' as a matter of law." 813 F. Supp. at 1007.

Defendants argue that the 13% and 11% surcharges are designed to affect the insurance marketplace by giving the Blues a competitive advantage over commercial insurers, self-insured funds, and a number of other players in the marketplace — and thus may be characterized as the regulation of insurance. This argument, however, confuses laws regulating the "business of insurance" with laws regulating hospital rates that have an effect on the "insurance marketplace." Although the surcharge laws clearly have some impact on insurance companies, this alone is not enough. As the Supreme Court has made clear in interpreting § 2(b) of the McCarran-Ferguson Act, there is a difference between the "business of insurance" and the "business of insurers." *See Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 210-17 (1979).

In our view, defendants' arguments proceed from an impermissibly broad reading of the saving clause. Congress intended that ERISA's preemption provision would clear the field of any state law interfering with benefit plans, *see, e.g., FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990); *Pilot Life*, 481 U.S. at 47-48, and installed the saving clause to preserve only those state laws precisely directed at the insurance business. The more expansively the saving clause is read, the more deeply it cuts into the preemption, a result that would render the entire scheme unworkable.

Nor do the McCarran-Ferguson factors suggest otherwise. The Blues — unlike commercial carriers — offer health insurance to anybody, no matter who they are or what physical shape they are in. As the insurer of last resort, the Blues insure persons and groups that are, on the whole, older and less healthy, and therefore constitute unacceptably high risks for other insurers. Most high risk policyholders, therefore, are insured under the Blues. Because the 13% and 11% surcharges are designed to encourage ERISA plans — with generally healthier persons — to shift to the Blues, the State's reimbursement system would help spread the risk of health care costs.

Group Life & Health Insurance Co. v. Royal Drug Co., 440 U.S. 205 (1979), does not alter this conclusion. There, the

Supreme Court ruled that Blue Shield's arrangement with certain pharmacies to charge Blue Shield's insureds only $2 for every prescription drug did not constitute the "business of insurance" under McCarran-Ferguson. As noted by the district court here, "[t]he Supreme Court held that the agreements between Blue Shield and the participating pharmacies did not spread any risk because those agreements merely reduced Blue Shield's costs for fulfilling an obligation which Blue Shield had already assumed." 813 F. Supp. at 1008 n.15 (citing *Royal Drug*, 440 U.S. at 212-14). Here, the challenged surcharges do not merely raise the cost of inpatient hospital services, but play a significant role in encouraging ERISA plans to shift to the Blues. Thus, unlike *Royal Drug*, the surcharges here can be said to have "the effect of transferring or spreading a policyholder's risk." *Pilot Life*, 481 U.S. at 48 (quoting *Union Labor Life Ins.*, 458 U.S. at 129).

The 13% and 11% surcharges, however, fail to satisfy the remaining two McCarran-Ferguson factors. These surcharges do not regulate any practice that is integral to the insurer-insured relationship. As we noted on an earlier occasion, the essence of the second McCarran-Ferguson factor is whether a statute "dictate[s] any of the terms of the insurance contract itself, the principal embodiment of the insurer-insured relationship." *Howard*, 901 F.2d at 1159. True, the surcharges here were designed to induce ERISA plans to switch their hospital coverage from commercial insurers to the Blues; but they do not directly change any of the terms, conditions or scope of coverage in commercial insurance contracts. Rather, because the surcharges expressly regulate hospital rates, they relate only to the contractual obligations between hospitals and insurers or insureds, but do not directly implicate the policy relationship between insurers and their insureds.

Finally, the surcharges are not "limited to entities within the insurance industry." *Pilot Life*, 481 U.S. at 49 (quoting *Union Labor Life Ins.*, 458 U.S. at 129). In *Howard*, a provision of the New York Insurance Law required that either the insurer or the employer (in certain circumstances) give notice of conversion privileges upon termination of employment. *Id.* at 1156.

We found that this provision was not a regulation of insurance. *Id.* at 1159. We noted that since the notice could be given by either the employer or the insurer, the law was not limited to entities within the insurance industry. *Id.* Here, the surcharges set rates that hospitals must charge patients, and thus involve entities beyond the insurance industry, including: the State, hospitals, patients, HMOs, and self-insured funds. Thus, the third McCarron-Ferguson factor is not satisfied.

Accordingly, because of our common-sense determination that the surcharges do not regulate insurance, and because two of the three McCarran-Ferguson factors are not satisfied, we agree with the district court that the 13% and 11% surcharges are not preserved by the saving clause. Accordingly, the New York statutes imposing the surcharges are preempted by ERISA.[5]

C. *The Actuarial Letter*

Self-insured employee benefit plans and their employer sponsors, including the Sheridan Catheter Plan (on whose behalf Travelers challenges the Actuarial Letter), often purchase stop-loss insurance to protect themselves against excess or catastrophic losses. Unlike traditional group-health insurance, stop-loss insurance is akin to reinsurance in that it does not provide coverage directly to plan members or beneficiaries. Rather, most stop-loss policies (and the policy issued to the Sheridan Catheter Plan here) provide coverage to the plan itself if the total amount of claims paid by the plan exceeds the amount of anticipated claims by a specified sum.

The Actuarial Letter under attack purports to regulate the terms of such stop-loss insurance contracts. Its relevant provisions follow:

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[5] We also agree with the district court that the 9% assessment does not "fall within the scope of the savings clause because HMOs . . . do not engage in the 'business of insurance' as a matter of law," 813 F. Supp. at 1007, and is thus preempted by ERISA. *See* discussion *supra* note 4.

Because we hold that ERISA preempts the three surcharges, we need not reach the issue whether the 13% and 11% surcharges are also preempted by FEHBA.

1. The insurer must undertake to ensure that statutorily mandated benefits be covered under the employer's plan;

2. The insurer must agree to ensure that statutory conversion policies be provided, either by them or by another insurer;

3. Notice must be given to employees if and when the insurer becomes liable for runoff claims. . . .

4. The insurer should maintain full runoff reserves. If the policyholder holds his own reserves, the insurer's claim reserves are to be replaced by a terminal premium payable immediately upon termination. . . .

5. The insurer must take full responsibility for the payment of all employer plan claims incurred but not yet paid at the date of termination of the policy . . .

The district court properly found that ¶¶ 1, 2, 3, and 5 of the Actuarial Letter "relate to" an employee benefit plan for purposes of ERISA's preemption clause. Paragraphs 1 and 5 on their face make specific "reference to" an employee benefit plan, and ¶¶ 2 and 3 clearly have a "connection with" such plans. *See Greater Wash. Bd. of Trade*, 113 S. Ct. at 583 (quoting *Shaw*, 463 U.S. at 97). ERISA therefore preempts ¶¶ 1, 2, 3, and 5 of the Actuarial Letter unless they find salvation in ERISA's saving clause as a law that regulates insurance, and even that salvation will be denied unless the employee benefit plan can escape the orbit of § 1144(b)(2)(B) refusing to deem such a plan "to be an insurance company or other insurer."

The district court concluded that ¶¶ 1, 2, 3, and 5 were preempted and the saving clause for insurance regulations did not save them because, under the deemer clause, self-insured employee benefit plans are not deemed to be "an insurance company or other insurer . . . ." *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990). The Department of Labor and Travelers, while agreeing with this result, suggest that the district court should

not have reached the deemer clause without first considering whether ¶¶ 1, 2, 3, and 5 regulate insurance at all, within the meaning of the saving clause. We agree. Accordingly, we affirm the district court's holding on a different ground: ¶¶ 1, 2, 3, and 5 are not saved from preemption because those paragraphs do not regulate insurance within the meaning of the saving clause.

As already discussed, in order to fall within the saving clause, the state law must constitute the regulation of insurance from a common-sense point of view and must also satisfy the McCarran-Ferguson factors. *See Pilot Life*, 481 U.S. at 48-49. The challenged provisions of the Actuarial Letter do neither.

Pilot Life's common-sense test does not validate every conceivable restriction on the sale of insurance contracts under the rubric of regulation of insurance. *See Howard*, 901 F.2d at 1158. We conclude that ¶¶ 1, 2, 3, and 5 of the Actuarial Letter use the regulation of stop-loss coverage as a pretext to regulate the terms of self-funded ERISA plans.

In ¶ 1 of the Actuarial Letter, the State permits a self-insured plan to obtain stop-loss coverage only if the plan provides its members and beneficiaries with the full panoply of benefits mandated by New York's Insurance Law. Paragraph 2 requires the plan to provide its beneficiaries with the right to a statutory conversion policy. Paragraphs 3 and 5 require the plan to afford its members a host of protections in case the plan becomes insolvent. Because the conditions imposed by the Actuarial Letter are not limited just to the stop-loss layer of insurance but apply generally to the entire plan, we conclude that ¶¶ 1, 2, 3, and 5 of the Letter do not, as a practical matter, regulate just insurance.

Furthermore, the challenged provisions of the Actuarial Letter do not satisfy the McCarran-Ferguson criteria. First of all, ¶¶ 1, 2, 3, and 5 do not have the effect of transferring or spreading risk between a self-funded plan and its stop-loss insurer but, instead, require the self-insured plan to provide additional benefits and protections to the plan's members and beneficiaries.

Second, the challenged provisions are not an integral part of a self-funded plan's relationship with its stop-loss insurer. Paragraph 1, for example, focuses squarely on the self-funded plan's relationship with its participants, not with the stop-loss insurer. Because employees are not insured under the terms of the stop-loss policy, requiring the stop-loss insurer to notify such individuals, as ¶ 3 does, is not an integral part of the insurance relationship. Likewise, because ¶ 5's purpose is to protect employees, who are not insured under the stop-loss contract, that paragraph is not an integral part of the insurance relationship between the plan and its stop-loss insurer.

Finally, ¶¶ 1, 2, 3, and 5 are not limited to insurance entities. Paragraph 1 is aimed directly at sponsors of self-funded plans. By requiring the sponsoring employer to provide conversion rights through another insurer if the stop-loss insurer does not provide such rights, ¶ 2 is aimed directly at employers who are not part of the insurance industry. *See Howard*, 901 F.2d at 1159 (state law requiring either insurer or employer to notify covered employees of conversion rights was not "limited to entities within the insurance industry"). Likewise, ¶ 3 states specifically that the Department of Insurance "will accept a policy provision which requires the employer to pass along [the notice] material." Thus, it too is not "limited to entities within the insurance industry." *See id.*

In sum, the challenged provisions of the Actuarial Letter satisfy neither the common-sense test nor the McCarran-Ferguson factors. Consequently, they do not fall within the saving clause and are preempted.

The district court also held that ¶¶ 4, 6, and 7 of the Actuarial Letter do not "relate to" ERISA plans and, accordingly, did not reach the saving clause argument as to those paragraphs. On cross-appeal, Travelers argues that the district court erred to the extent it found that ¶ 4 does not "relate to" ERISA plans.[6] We

[6] The district court's findings as to ¶¶ 6 and 7 are not now challenged by Travelers or the Department of Labor.

agree and therefore reverse that part of the district court's decision holding that ¶ 4 is not preempted.

Paragraph 4, like ¶¶ 1, 2, 3, and 5 of the Actuarial Letter, is directed at the purchasers of stop-loss coverage which are primarily ERISA plans. It effectively requires the "policyholder" – which is an ERISA plan – either to purchase insurance for "run-off claims" or maintain significant reserves of its own. This alone merits a finding that ¶ 4 has a "connection with" employee benefit plans and, therefore, is "relate[d] to" such plans for purposes of ERISA's preemption clause because stop-loss protection will guarantee that benefits are paid to employees even if the carrier suffers catastrophic losses.

Reaching the saving clause argument, we conclude that ¶ 4 does not "regulate insurance" and therefore is not saved from ERISA preemption. In our view, ¶ 4 attempts to regulate, through the self-loss insurer, the benefits offered by and the administrative functioning of self-funded ERISA plans. Paragraph 4 is similar to the other challenged paragraphs. Like ¶¶ 1, 2, 3, and 5 of the Actuarial Letter, ¶ 4 does not fall within the saving clause and is, therefore, preempted.

We hold, therefore, that the five challenged paragraphs do not regulate insurance within the meaning of the saving clause and, accordingly, are preempted. We affirm the district court's ruling as to ¶¶ 1, 2, 3, and 5 of the Actuarial Letter, and reverse as to ¶ 4.

CONCLUSION

To sum up: We find that the district court properly found that plaintiffs' challenges to the 11% and 9% surcharges are not barred by the TIA. Nor is their challenge to the 13% differential barred by laches. Further, the district court properly held that the three surcharges are preempted by ERISA. Finally, we affirm the court's decision as to ¶¶ 1, 2, 3, and 5 of the Actuarial Letter, and reverse as to ¶ 4.

Accordingly, the judgment of the district court is affirmed in part, reversed in part, and the district court is directed to enter judgment consistent with this opinion.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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The Travelers Insurance Company,

Plaintiff,

New York State Health Maintenance Organization Conference,

Intervenor,

-against-

Mario M. Cuomo, in his Official Capacity as Governor of the State of New York, et al.,

Defendants,

New York State Conference of Blue Cross and Blue Shield Plans, Empire Blue Cross and Blue Shield, and Hospital Association of New York State,

Intervenors.

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92 Civ. 3999 (LJF) Opinion and Order

The Health Insurance Association of America, et al.,

Plaintiffs,

New York State Health Maintenance Organization Conference,

Intervenor,

-against-

Mark Chassin, M.D. in his Official Capacity as Commissioner of Health of the State of New York, et al.,

Defendants,

New York State Conference of Blue Cross and Blue Shield Plans, Empire Blue Cross and Blue Shield, and Hospital Association of New York State,

Intervenors.

----------X

92 Civ. 5419 (LJF) Opinion and Order

LOUIS J. FREEH, U.S.D.J.

These consolidated actions involve a challenge by plaintiffs The Travelers Insurance Company ("Travelers") and The Health Insurance Association of America ("HIAA"), among others, to a number of New York statutes imposing surcharges on the hospital rates for certain categories of payors (the "Surcharges"). Travelers also challenges a Department of Insurance letter interpreting some of those provisions (the "Actuarial Letter").

In their complaints, plaintiffs claim that the Surcharges and Actuarial Letter are preempted by the Employee Retirement Income Security Act of 1974 ("ERISA") and the Federal Employee Health Benefit Act ("FEHBA"). Plaintiffs now move for summary judgment. The New York State Health Maintenance Organization Conference (the "HMOs") has intervened and filed briefs in support of that motion. The United States has also filed an *amicus curiae* brief in support of plaintiffs' FEHBA claims.

Defendants oppose plaintiffs' motion and cross-move for summary judgment on all of plaintiffs' claims. The New York State Conference of Blue Cross and Blue Shield Plans, Empire Blue Cross and Blue Shield (collectively, the "Blues") and the Hospital Association of New York State ("HANYS") have intervened and filed briefs in support of defendants' position.

For the reasons stated below, plaintiffs' motion for summary judgment is granted in part and denied in part. Defendants' cross-motion is denied. In sum, the Court finds that (1) the Tax Injunction Act does not preclude an injunction against the 9% and 11% Surcharges; (2) the three statutory provisions at issue are all preempted by ERISA; (3) plaintiffs' claims as to the 13% Surcharge are not barred by the doctrine of laches; (4) both the 11% and 13% Surcharges are preempted by FEHBA; and (5) items 1, 2, 3 and 5 of the Actuarial Letter are also preempted by ERISA.

BACKGROUND

As stated in the Court's prior orders dated November 10 and December 17, 1992, this case involves New York's comprehensive statutory scheme for the regulation of in-patient hospital

rates. As a general rule, a patient's hospital rate is determined by the patient's diagnosis, which governs the particular category, or Diagnosis Related Group ("DRG"), to which the case is assigned. The hospital charges patients the rate applicable to their assigned DRG, subject to certain adjustments reflecting costs specific to that hospital.

Section 2807-c(1)(b) of New York's Public Health Law provides that the DRG rate for inpatient services is increased by 13% for all patients covered by any form of health insurance other than Blue Cross and Blue Shield, a health maintenance organization ("HMO") or a government plan such as Medicare (the "13% Surcharge"). Thus, patients who have hospital coverage through commercial insurers or self-insured employee benefit plans pay 113% of the applicable DRG rate, while patients who have hospital coverage through the Blues, an HMO or a government plan pay the basic DRG rate. The 13% surcharge is paid directly to the hospital.

On April 2, 1992, the New York State Legislature adopted the Omnibus Revenue Act of 1992 (the "1992 Act"), which amends the Public Health Law to impose an additional 11% surcharge on rates charged to patients insured by commercial insurers (the "11% Surcharge"). The proceeds of the 11% Surcharge are initially paid by commercial insurers to the hospital, but the hospital must then submit the funds to a pool established by the Commissioner of Health. The 11% Surcharge is then deposited into the State's General Fund.

In addition to the 11% Surcharge, the 1992 Act imposes a surcharge of up to 9% on the hospitalization cost of patients covered by HMOs (the "9% Surcharge"). While HMOs may reduce the 9% Surcharge by enrolling a specified number of Medicaid patients, HMOs which do not or cannot meet the statutory requirements must pay the full amount. Unlike the 11% Surcharge, the 9% Surcharge is not paid to the state through the hospital. Rather, each HMO must pay the surcharge funds directly into a statewide pool established by the Commissioner for Social Services. Like the 11% Surcharge, however, the 9% Surcharge is ultimately deposited into the State's General Fund.

Plaintiffs filed this action, claiming that the statutory surcharges and the Actuarial Letter are preempted under ERISA and FEHBA. Defendants disagree, and argue that the statutes at issue constitute a legitimate exercise of the State's power to regulate hospital rates and/or insurance.

DISCUSSION

1. *The Tax Injunction Act*

As an initial matter, the court must determine whether the Tax Injunction Act (the "TIA"), 28 U.S.C. § 1341, bars plaintiffs' claims as to the 9% and 11% Surcharges. The TIA provides that:

> The district courts shall not enjoin, suspend or restrain the assessment, levy or collection of any tax under State law where a plain, speedy and efficient remedy may be had in the courts of such state.

Thus, to determine whether a particular action falls within the scope of the TIA, a federal district court must determine (1) whether the charge at issue is a "tax," and (2) whether the State provides a "plain, speedy and efficient remedy."

The State, presumably the party with the greatest interest in such matters, has not relied upon the TIA in their papers before this Court. The Blues argue, however, that the TIA applies here because the 9% and 11% Surcharges constitute a state tax which could be challenged in New York state court.

The Court disagrees. Even assuming that the Surcharges are "taxes" within the meaning of the TIA,[1] an action to enjoin such

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[1] As discussed more fully below, the State's purpose in enacting the 9% and 11% Surcharges is not entirely clear. That purpose is central, however, to a determination whether the Surcharges constitute "taxes" within the meaning of the TIA. As other courts have noted, "[i]n general, 'assessments imposed primarily for revenue-raising purposes are 'taxes,' while those levies assessed for regulatory or punitive purposes, even though they may also raise revenues are generally not 'taxes.' " *United Wire, Metal & Machine Health and Welfare Fund v. Morristown Memorial Hospital*, 793 F. Supp. 524, 530 (D.N.J. 1992)

(Footnote continued)

taxes as violations of ERISA falls within a judicially-created exception to the TIA. *See National Carriers' Conference Committee v. Heffernan*, 440 F. Supp. 1280 (D. Ct. 1977).

In *Heffernan*, then District Judge Newman denied a motion to dismiss an ERISA plan's challenge to a Connecticut state tax on benefits paid out under the plan. 440 F. Supp. at 1281. In making that ruling, Judge Newman specifically found that because the United States could have brought the action at issue and because "[t]he very terms of ERISA indicate that Congress intended private plaintiffs' access to the federal courts to be no less than that of the Secretary of Labor's," the plaintiff came within the "federal instrumentalities" exception to the TIA. *Id.* at 1284.

The same holds true in this case. There can be no doubt that the Secretary of Labor could have filed an action to enjoin the Surcharges at issue. *See* 29 U.S.C. § 1132(a)(5) (Secretary may sue "to enjoin any act or practice which violates" ERISA, or "to obtain other appropriate equitable relief"); *Heffernan*, 440 F. Supp. at 1284 (discussing federal government's interest in ERISA plans). As a result, private parties such as plaintiffs are also entitled to do so.[2]

(*quoting Butler v. Maine Supreme Judicial Court*, 767 F. Supp. 17, 18 (D. Me. 1991)). However, to the extent that the 9% and 11% Surcharges are paid into New York's General Fund, they appear to be taxes. *Compare United Wire*, 793 F. Supp. at 531 (finding that revenues generated by New Jersey hospital rate-setting statute do not constitute taxes because not "intermingled in a general fund" or used "for the general welfare").

[2] The Supreme Court has declined to decide whether ERISA either creates or falls within an already existing exception to the TIA. *See Franchise Tax Bd. v. Construction Laborers Vacation Trust*, 103 S.Ct. 2841, 2852 and n.21 (1983). The Ninth Circuit has held that no such exception exists, although the Court did not discuss the federal instrumentality exception relied upon in *Heffernan*. *See Ashton v. Cory*, 780 F.2d 816, 821-22 (9th Cir. 1986) ("Nothing in the legislative history of ERISA suggests that in enacting federal law to . . . provid[e] for exclusive federal jurisdiction over certain civil enforcement proceedings under ERISA, Congress sought to override the historic concern

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In any event, the Court finds that these plaintiffs do not have a "plain, speedy and efficient" remedy in New York state court. Because ERISA generally confers exclusive jurisdiction on the federal courts, a New York state court "might well feel compelled to dismiss [a state court action] on the grounds that its jurisdiction has been preempted. . . [Thus,] [a]t a minimum the availability of a state court remedy is not 'plain.'" *Heffernan*, 440 F. Supp. at 1283.

It is also unclear whether plaintiffs have any remedy in state court at all. Plaintiffs are suing here in their capacity as fiduciaries for ERISA plans. However, the New York statute is structured so that ERISA plans do not themselves pay the Surcharges. As a result, plaintiffs are not "taxpayers," and could not file a declaratory judgment action in state court to enjoin enforcement of the taxes at issue. (Blues Brief at 43). *Compare Morgan Guaranty Trust Company of New York v. Tax Appeals Tribunal*, 587 N.Y.S.2d 252 (1992) (ERISA plan itself paid challenged tax on capital gains from real estate transfer).

Plaintiffs are also precluded from seeking reimbursement in the New York Court of Claims. Again, although plaintiffs could sue on their own behalf to recover monies improperly paid to the State, plaintiffs could not sue on behalf of ERISA plans, because those plans do not pay the Surcharges. Accordingly, the parties on whose behalf plaintiffs are acting – the plans themselves – have no plain and efficient remedy in New York state Courts.

2. *ERISA Preemption*

a. *General Principles of Preemption*

In determining whether a federal statute preempts a state law, Congress' intent controls. *FMC Corp. v. Holliday*, 111 S.Ct.

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for state fiscal autonomy that underlies the [TIA]."). *See also Retirement Fund Trust v. Franchise Tax Board*, 909 F.2d 1266, 1272 (9th Cir. 1990); *General Motors Corp. v. California Board of Equalization*, 815 F.2d 1305, 1308 (9th Cir. 1987), *cert. denied*, 485 U.S. 941 (1988). However, other courts have disagreed with the Ninth Circuit. *See, e.g., E-Systems, Inc. v. Pogue*, 929 F.2d 1100, 1102 (5th Cir.), *cert. denied*, 112 S.Ct. 585 (1991).

403, 407 (1990). "If the intent of Congress is clear, that is the end of the matter; for the court . . . must give effect to the unambiguously express intent of Congress." *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 104 S.Ct. 2778, 2781 (1984). *See also Cipollone v. Liggett Group, Inc.*, 112 S.Ct. 2608, 2617 (1992) (congressional intent " 'is the ultimate touchstone' of preemption analysis") (*quoting Malone v. White Motor Corp.*, 98 S.Ct. 1185, 1189 (1978)). At the same time, a court must presume that Congress did not intend to preempt "areas of traditional state regulation." *Metropolitan Life Ins. Co. v. Massachusetts*, 105 S.Ct. 2380, 2389 (1985).

ERISA's preemption clause is notably broad. *See* 29 U.S.C. § 1144(a); *FMC Corp.*, 111 S.Ct. at 407 ("The [ERISA] pre-emption clause is conspicuous for its breadth."). That provision states that, except as provided in the savings clause, "the provisions of this subchapter . . . shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . ."

The Supreme Court has held that a law "relates to" an employee benefit plan "in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Ingersoll-Rand Co. v. McClendon*, 111 S.Ct. 478, 483 (1990). *See also Shaw v. Delta Air Lines Inc.*, 103 S.Ct. 2890, 2900 (1983). Thus, preemption is not precluded merely because a law is not specifically designed to effect employee benefit plans, or because it does not deal exclusively with subjects covered by ERISA. *FMC Corp.*, 111 S.Ct. at 408. To the contrary, a state law may be preempted even if it is consistent with ERISA's substantive requirements. *Metropolitan Life*, 105 S.Ct. at 2389. Moreover, as the Second Circuit recently noted, even "a state law of general application, with only an indirect effect on a pension plan, may nevertheless be considered to 'relate to' that plan for preemption purposes." *Smith v. Dunham-Bush, Inc.*, 959 F.2d 6, 9 (2d Cir. 1992); *Ingersoll-Rand*, 111 S.Ct. at 483 (state law may relate to a benefit plan and be preempted even if effect on that plan is only indirect).[3]

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[3] *See also District of Columbia v. Washington Trade Bd.*, 113 S.Ct. 580, 583 (1992) (Supreme Court's interpretation of phrase "relate to" is "true to the

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As other courts have noted, the legislative history of ERISA also supports a broad reading of the preemption clause. *See McCoy v. Massachusetts Institute of Technology*, 950 F.2d 13, 17 (1st Cir. 1991) (legislative history "counsels against a crabbed interpretation of the statute"), *cert. denied*, 112 S.Ct. 1939 (1992). The bill that became the ERISA statute originally contained a much narrower preemption provision. *Shaw*, 103 S.Ct. at 2901. However, the Conference Committee rejected that more restrictive language, and substituted the current provision. *Id.* at 2900.

Although expansive, ERISA's preemption clause does have certain well-established limits. For example, the Supreme Court has expressly acknowledged that "[s]ome state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." *Shaw*, 463 U.S. at 100 n.21. *See, e.g., Mackey v. Lanier Collections Agency & Service, Inc.*, 108 S.Ct. 2182, 2186-91 (1988) (generally applicable garnishment law not preempted); *Fort Halifax Packing Co. v. Coyne*, 107 S.Ct. 2211, 2215 (1987) (one-time severance payment not preempted).

In addition, ERISA itself contains a "savings clause" which states that "[e]xcept as provided . . . nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." 29 U.S.C. 1144(b)(2)(A). Thus, to the extent that the New York laws at issue here have only a peripheral impact on ERISA plans, or regulate insurance within the meaning of the savings clause, those laws will not be preempted.[4]

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ordinary meaning" of the term, and "gives effect to the 'deliberately expansive' language chosen by Congress"); *Alessi v. Raybestos-Manhattan Inc.*, 101 S.Ct. 1895, 1907 (1981) ("It is of no moment that New Jersey intrudes indirectly through a worker's compensation law, rather than directly, through a statute called 'pension regulation.' ").

[4] As discussed more fully below, ERISA also contains a "deemer" clause, which limits the scope of the savings clause, and provides that "[n]either an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer . . . to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts . . ." 29 U.S.C. § 1144(b)(2)(B).

b. *"Relates To"*

Although the 9%, 11% and 13% Surcharges do not expressly refer to ERISA plans, it is clear that those statutes have a "connection with" such plans. *See United Wire*, 793 F. Supp. at 535 ("The fact that these provisions do not mention benefit plans directly and do not regulate the terms and conditions of such plans explicitly, has no bearing on this Court's findings."). Accordingly, the Court finds that the Surcharges are preempted by ERISA unless they fall within the scope of the savings clause.

The parties dispute the exact impact of the Surcharges on ERISA plans. (*See* Defendants' Brief at 15-21) (discussing "tenuous and remote" economic effect of statute). Under the statutes' current framework, the Surcharges do not directly increase a plan's costs or effect the level of benefits to be offered. However, there can be little doubt that the Surcharges at issue will have a significant effect on the commercial insurers and HMOs which do or could provide coverage for ERISA plans[5] and thus lead, at least indirectly, to an increase in plan costs. Plaintiffs have submitted affidavits stating that if the Surcharges are enforced against them, they will pass along those increased costs[6] to their customers, including employee

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[5] Defendants do not dispute that commercial insurers provide benefits to a substantial number of employee benefits plans in New York. (*See* Musco Aff. ¶ 9; Donnelly Aff. ¶ 4) (in New York, as elsewhere, "vast majority" of purchasers of commercial insurance are covered pursuant to ERISA plan); (Welch Aff. ¶ 7; Burke Aff. ¶ 2) (describing plans covered by Aetna). Defendants also do not dispute that under New York law, employee benefit plans are required by statute to offer HMO coverage to their members. *See* Public Health Law § 4407.

[6] (*See, e.g.*, Allen Aff. ¶ 22) (9% Surcharge translates into an immediate 2.5% - 3.5% increase in HMO costs); (Welch Aff. ¶ 11-12) (13% Surcharge increases costs for both self-insured and insured plans).

Defendants dispute plaintiffs' characterization of the 13% Surcharge as an "increase" in the commercial insurers' costs, given that the 13% differential was initially imposed to reduce the then-existing disparity between hospital

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benefit plans.[7]

More importantly, defendants' entire justification for the Surcharges is premised on that exact result – that the Surcharges will increase the cost of obtaining medical insurance through any source other than the Blues to a sufficient extent that customers will switch their coverage to and ensure the economic viability of the Blues.[8] (*See, e.g.*, Defendants' Brief at 34) ("An increase in the [13%] differential was considered necessary to prevent the continuing shrinkage of the Blue Cross community pools."); (Weissman Reply Aff. ¶ 8) (surcharges permit the

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rates for commercial insurers and the Blues. (*See, e.g.*, Rosenberg Reply Aff. ¶ 6). The parties also disagree as to whether the commercial insurers originally supported or opposed the 13% Surcharge. Without resolving these disputes, the Court finds that, to the extent the 13% Surcharge does impose higher hospital rates for patients covered by commercial insurers than those covered by the Blues (1) that Surcharge statutorily mandates increased costs for the commercial insurers; and (2) the commercial insurers pass those increased costs on to their customers. (Sujecki Aff. ¶¶ 4-6). Whether a "differential" would naturally exist between commercial insurers and the Blues in the absence of state regulation is irrelevant to an analysis whether, under ERISA, a state may impose such a differential.

[7] (*See* Allen Aff. ¶¶ 27) (by April 1993 "many" HMO subscribers will pay an additional 2.5% - 3.5%); (D'Ascoli Aff. ¶ 7) (surcharges will "significantly increase" amount Aetna HMO must charge participants); (Welch Aff. ¶¶ 12-13) (under Aetna's agreements with ERISA plans, surcharges "also increase the amounts that sponsors of plans . . . must pay for that coverage"); (Burke Aff. ¶ 7) (increase in costs of health care have "substantial effect" on premiums charged); (Gutterman Aff. ¶ 9 and Sujecki Aff. ¶¶ 2-3) (Travelers has and will continue to pass its increased costs along to customers in form of increase premiums).

In fact, a number of HMOs have already applied to the State Insurance Department for rate increases, based, at least in part, on the 9% surcharge. (*See* Rachlin Aff. and exhibits thereto). At least two of those applications have been granted. (*Id.* Exs. A and B).

[8] This justification is, itself, open to question. At least as to the 9% and 11% Surcharges, it appears that a major purpose of the legislation was to balance the State's budget. (*See* Petersen Aff. ¶¶ 4-7; Weissman Reply Aff. ¶ 26). (*See also* Andersen Aff. ¶ 25) (11% Surcharge paid directly to State "[b]ecause of State's own pressing fiscal needs).

Blues "to remain competitive").[9] Thus, even if the exact economic effect of the Surcharges cannot be determined at this stage in the litigation, the Court finds that that effect is intended to be and is in fact substantial.

Defendants argue that because the Surcharges do not impact the structure or administration of employee benefit plans, impose requirements on use of plan resources, or impose inconsistent obligations upon multi-state plans, those statutes do not "relate to" the plans for preemption purposes. (Defendants' Brief at 21-28). As indicated above, the Supreme Court does not condition a finding of ERISA preemption upon a showing of any of the three factors relied upon by the State. Rather, the Supreme Court has found that ERISA's preemption clause should be "given its broad common-sense meaning." *Metropolitan Life*, 105 S.Ct. at 2389. While the factors relied upon by defendants may be relevant to the preemption inquiry, they are not dispositive.[10]

Even under defendants' analysis, however, the Surcharges have a sufficient impact on ERISA plans to be preempted. To the extent that the Surcharges impose a substantial economic burden on the commercial insurers and HMOs which provide services to employee benefit plans, those Surcharges may effect the structure and/or administration of such plans. *Compare United Wire*,

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[9] (*See also* Weissman Reply Aff. ¶¶ 11-14) (Gallup poll indicates that majority of small groups cancelling with Empire Blue Cross and Blue Shield did so because of cost differential between Empire and commercial insurers); (Clyne Aff. ¶ 18-19) (discussing importance of maintaining community-rated pools of insurance).

[10] *See also Firestone Tire & Rubber Co. v. Neusser*, 810 F.2d 550, 555-56 (6th Cir. 1987) (in determining whether statute's impact on ERISA plan is too remote or peripheral, three factors should be considered: whether state law represents traditional exercise of state authority, whether the law effects the relation between "principal ERISA entities – the employer, the plan fiduciaries, and the beneficiaries, and whether the impact of the statute on an ERISA plan is merely "incidental"); *Aetna Life Ins. Co. v. Borges*, 869 F.2d 142, 146 (2d Cir. 1989) (ERISA preemption triggered "not just [by] any indirect effect on administrative procedures but rather an effect on the primary administrative functions of benefit plans . . ."), *cert. denied*, 493 U.S. 811 (1989).

793 F. Supp. at 536 (New Jersey hospital rate-setting statute, which provides certain payors with discounts from the usually-applicable DRG rate, "affect[s] the structure of the [plans] themselves"). The Court has already found that commercial insurers and HMOs pass at least a portion of their increased costs on to the plans. In response to those increases, the plans may reduce the level of benefits or services offered rather than increase costs to participants – a burden on plan administration which ERISA was designed to avoid. *See E-Systems*, 929 F.2d at 1103 (Texas statute preempted because "[t]he cost of the plan must ... increase ... or the benefits must be adjusted downwards to offset the tax bite[,] ... [precisely] the type of impact Congress intended to avoid when it enacted the ERISA legislation"); *General Electric v. Department of Labor*, 891 F.2d 25, 29 (2d Cir. 1989) (statute has "connection with" ERISA plan if it "prescribes either the type and amount of an employer's contributions to a plan, the rules and regulations under which the plan operates, or the nature and amount of the benefits provided thereunder") (citations omitted), *cert. denied*, 496 U.S. 912 (1990).

Similarly, even an indirect increase in plan costs imposes "requirements" on use of plan resources. In fact, it diverts a not-insignificant amount of those resources to a State-specified use which is unrelated to the health care of plan participants. *See United Wire*, 793 F. Supp. at 535 (discounts to certain payors of hospital bills "force [ERISA plans] to incur costs for the benefit of others ...").

Finally, as discussed more fully below, if plans do opt to change the level of benefits offered rather than pass their increased costs on to participants, the Surcharges will, at least indirectly, impose inconsistent obligations upon multi-state plans – exactly the type of burden ERISA's preemption clause was intended to prevent. *See United Wire*, 793 F. Supp. at 535 and n.15 (New Jersey statute may subject plans to inconsistent regulations given that other states may not include similar costs in their hospital rates). *See also Ingersoll*, 111 S.Ct. at 484 (state laws which impose different substantive standards require "the tailoring of plans and employer conduct to the peculiarities of the

law of each jurisdiction . . . [and are] fundamentally at odds with the goal of uniformity that Congress sought to implement").

c. *Rebaldo v. Cuomo*

Defendants argue that the Surcharges do not "relate to" ERISA plans within the meaning of ERISA's preemption clause because they are laws of general application, which have only a peripheral impact on the plans. (Defendants' Brief at 13; HANYS Brief at 13-14; Blues' Brief at 14). In making this argument, defendants rely on *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985), a case in which the Second Circuit ruled that New York's prior hospital rate-setting statute, which granted patients covered by Blue Cross a 12-15% discount from the DRG rate, was not preempted by ERISA. 749 F.2d at 139 ("Where, as here, a State statute of general application does not affect the structure, the administration, or the type of benefits provided by an ERISA plan, the mere fact that the statute has some economic impact on the plan does not require that the statute be invalidated."). However, because the Court finds that *Rebaldo* has been abrogated by later Supreme Court cases, that case is not controlling here.

In *Rebaldo*, the Second Circuit held that "a state law must 'purport[] to regulate, . . . the terms and conditions of employee benefit plans' to fall within the preemption provision." 749 F.2d at 137. As the Second Circuit has itself recognized, the Supreme Court has "expressly rejected" that limitation on ERISA preemption.[11] *See Smith*, 959 F.2d at 9 n.3 (*citing Ingersoll-Rand*, 111 S.Ct. at 484).

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[11] The fact that the Second Circuit recently cited *Rebaldo* does not undermine the Court's own recognition that the case is of questionable validity for these purposes. The issue in *Medical Society of the State of New York v. Cuomo*, 976 F.2d 812 (2d Cir. 1992), was preemption under the Health Insurance for the Aged Act or Medicare Act, not ERISA. While the Second Circuit did cite *Rebaldo* for the proposition that "regulation of public health and the cost of medical care" are traditionally matters for the state, 976 F.2d at 816, the Court distinguished *Rebaldo* from the *Medical Society* case on the grounds that *Rebaldo* (and ERISA) involved an express preemption clause, which the Medicare Act did not. *Id.* at 817.

Despite this, defendants argue that the remainder of the case is still good law. The Court disagrees. In *Rebaldo*, the Second Circuit's "purport to regulate" language appears in the very beginning of the Court's discussion of ERISA preemption. 749 F.2d at 137. Therefore, as this Court reads the case, that initial finding colored the rest of the Court's analysis of ERISA, and contributed significantly to its holding.

Even putting aside *Rebaldo*'s "purport to regulate" language, it seems clear that a number of the factors relied upon by the Second Circuit to uphold New York's prior hospital rate-setting statute have now been rejected by the Supreme Court. For example, the Court stated that the "mere fact" that a state statute has "some economic impact" on an ERISA plan does not require that the statute be invalidated. 749 F.2d at 139. That may be true if the economic impact is only incidental. *See Shaw*, 463 U.S. at 100 n.21. However, to the extent that the Supreme Court has expressly recognized that even an indirect impact on an ERISA plan may require a finding of preemption, economic impact alone may be enough to invalidate a particular statute.

In asserting the contrary rule, defendants and intervenors rely heavily on *Rebaldo*'s discussion of the economic impact of hospital rates on ERISA plans:

> The purchase of hospital service is like the purchase of public utility service, or of any other service or commodity whose price is controlled by the State. Insofar as the regulation of hospital rates affects a plan's cost of doing business, it also may be analogized to State labor laws that govern working conditions and labor costs, to rent control laws that determine what employee benefit plans pay or receive for rental property, and even to such minor costs as the Thruway, bridge and tunnel tolls that are charged to plans' officers or employees. In short, if ERISA is held to invalidate every State action that may increase the cost of operating employee benefit plans, those plans will be permitted a charmed existence that never was contemplated by Congress.
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> [749 F.2d at 138-39].

In making this statement, the Second Circuit appears to have assumed that the economic impact of the hospital rate-setting statute on ERISA plans was both insubstantial and indirect. It is true that certain statutes might have such an insignificant economic impact on employee benefit plans that they could be compared to rent control laws. However, as discussed above, statutes like those at issue in this case – which are expressly directed at the cost of medical care – are likely to have a substantial, although indirect, impact on either a plan's costs or benefits, an impact which falls within the preempted sphere of ERISA.

The *Rebaldo* court also stated that "[t]here is no valid reason why employee benefit plans cannot be subject to nationally uniform supervision despite dissimilarities in their costs of doing business." 749 F.2d at 139. But if, as here, the dissimilarities in cost are substantial, they would "require plan providers to calculate benefit levels in [New York] based on expected liability conditions that differ from those in States that [do not impose such costs]."[11] *FMC Corp.*, 111 S.Ct. at 408. Therefore, to the extent that the increased costs affect plans' decisions regarding level of benefits, those costs "would . . . frustrate plan administrators' continuing obligation to calculate uniform benefit levels nationwide." *Id.* at 409.

Defendants correctly note that, to the extent that the Court finds that New York's statutes "relate to" employee benefit plans, then "ERISA preempts all state hospital rate-setting statutes, at least to the extent they apply to rates charged to patients that

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[11] Defendants appear to concede this point, by arguing that even if commercial insurers do experience increased costs as a result of the statutory surcharges, they can avoid passing those costs along to ERISA plans by reducing the level of benefits offered. (Defendants' Brief at 19 and n.15). However, an indirect requirement that a plan reduce its benefits in a single state, based on that state's distinctive law, is exactly the type of conflicting obligation that ERISA's preemption clause was designed to avoid. *See FMC*, 111 S.Ct. at 408 ("To require plan providers to design their programs in an environment of differing State regulations would complicate the administration of nationwide plans, producing inefficiencies that employers might offset with decreased benefits.").

are participants in ERISA plans which include hospital expenses as a benefit." (Defendants' Brief at 25 n.19). This result is obviously undesirable in that it greatly complicates states' efforts to regulate and control hospital costs. But given the breadth of ERISA's preemption clause and the Supreme Court's recent interpretations of that provision, such a consequence may necessarily occur. As the Supreme Court has itself noted, "[a]rguments as to the wisdom" of such a broad preemption rule "must be directed at Congress," not the courts. *Metropolitan Life*, 105 S.Ct. at 2393.

d. *The Savings Clause*

Having found that the Surcharges all have a substantial economic impact on and thus connection with ERISA plans, the Court must now determine whether those surcharges fall within the scope of ERISA's "savings clause," which provides that "[e]xcept as provided . . . nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." 29 U.S.C. 1144(b)(2)(A).

In determining whether a particular state law is saved from preemption under this clause, a court must first determine whether the law "regulates insurance," that is, whether the law not only has an impact on the insurance industry, but is "specifically directed toward that industry." *Pilot Life Insurance Company v. Dedeaux*, 107 S.Ct. 1549, 1554 (1987); *Howard v. Gleason Corp.*, 901 F.2d 1154, 1158 (2d Cir. 1990). A court must also consider whether the law satisfies the three criteria for determining whether a practice constitutes "the business of insurance" under the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq*. *Pilot Life*, 107 S.Ct. 1553. Those criteria are:

> *First*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry.

Id. (*quoting Union Labor Life Ins. Co. v. Pireno*, 102 S.Ct. 3002, 3009 (1982)) (emphasis in original).[13]

(i) *Regulating Insurance*

Applying these factors to the Surcharges, it is clear that none of them qualify as laws "regulating insurance" within the meaning of the savings clause. As an initial matter, the Court finds that both the 9% Surcharge and those portions of the 13% Surcharge referring to self-insured plans could not possibly fall within the scope of the savings clause because HMOs and self-insured plans do not engage in the "business of insurance" as a matter of law. *See FMC Corp.*, 112 S.Ct. at 409 (holding that self-funded ERISA plans "are exempt from state regulation insofar as that regulation 'relate[s] to' the plans"); *O'Reilly v. Ceuleers*, 912 F.2d 1383, 1389 (11th Cir. 1990) (health maintenance organization does not engage in the business of insurance for purposes of ERISA); *McManus v. Travelers Health Network of Texas*, 742 F. Supp. 377, 382 n.5 (W.D. Texas 1990) (because Texas "HMO Act" is not "specifically directed" at the insurance industry, it does not fall within scope of ERISA savings clause).[14]

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[13] In *Pilot Life*, the Supreme Court also evaluated the law at issue – common law tort and contract claims for improper processing of benefits – in light of the role of the savings clause in ERISA as a whole. Such an analysis was considered necessary because ERISA itself contained provisions addressing the identical subject. 107 S.Ct. at 1555. By contrast, the Surcharges do not implicate substantive ERISA provisions. Accordingly, this last aspect of the *Pilot Life* case does not apply here.

[14] At least one court has reached the opposite conclusion, and found that, like insurers, HMOs "assume the financial risk of providing benefits to their members," and thus should be considered insurers for purpose of ERISA savings clause. *See Physicians Health Plan v. Citizens Ins. Co.*, 673 F. Supp. 903, 907-08 (W.D. Mich. 1987).

This Court respectfully disagree. New York law defines a health maintenance organization as "any person, natural or corporate, or any groups of such persons who enter into an arrangement, agreement or plan or any combination

(Footnote continued)

It is also clear that the 11% Surcharge and the remaining portions of the 13% Surcharge are not "specifically directed" at the insurance industry. To the contrary, as defendants themselves appear to concede, the Surcharges' primary goal is to regulate hospital rates, not commercial insurers. (*See* Defendants' Brief at 10, 13) (referring to law at issue as "New York's hospital rate-setting statute," and specifically stating that the law "regulates hospitals"); (Anderman Aff. ¶ 29) (noting that "differentials" are "simply part of a matrix of statutorily mandated State controls imposed on hospitals in New York").

(ii) *McCarran-Ferguson Criteria*

Given these findings, the Court must next consider whether the Surcharges satisfy any of the McCarran-Ferguson criteria. With regard to the "spreading of the risk" factor, the Court finds that the 11% and 13% Surcharges do, at least minimally, spread the risk of insuring high risk individuals. Although plaintiffs dispute the degree to which the Surcharges actually achieve their stated goal — to encourage the community rating and open enrollment procedures employed, at least in part, by the Blues — plaintiffs do not deny that, unlike the Blues, most if not all commercial insurers have not adopted those procedures at this time. (*See* HIAA Reply Brief at 21-22). Thus, plaintiffs cannot dispute that the Blues cover a disproportionate share of high risk individuals.

The Court has already found that increasing hospital rates for individuals covered by commercial insurers will result in an increase in premiums and that the increase in premiums will cause at least some individuals to obtain their insurance through

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of arrangements or plans which propose to provide or offer, or which do provide or offer, a comprehensive health services plan." Public Health Law § 4401(1). New York law further defines a comprehensive health services plan as "a plan through which each member of an enrolled population is entitled to receive comprehensive health services in consideration for a basic advance or periodic charge." Thus, unlike the typical insurance arrangement in which a medical insurer merely reimburses the patient for medical costs incurred, an HMO actually provides medical services for a fee.

the Blues rather than commercial insurers. Although difficult to quantity at this state in the litigation, this shift will likely increase the number of Blue Cross and Blue Shield members and spread the risk of high risk individuals among a larger pool. To this extent, therefore, the 11% and 13% Surcharges do have the effect of spreading certain policyholders' risks.[15]

The Surcharges do not, however, satisfy the two other McCarran-Ferguson factors. Neither the 11% nor the 13% Surcharges relate directly to the policy relationship between the insurer and the insured; rather, as noted previously, the statutes are expressly aimed at hospital rates. If the Surcharges directly impact any "relationship" at all, it is the relationship between insurers and hospitals or insureds and hospitals, not that between insurers and their insureds.

The Surcharges are also not limited to the insurance industry. To the contrary, the statutes at issue repeatedly refer to hospitals, HMOs, and self-insured benefit plans — entities which are not directly involved with the issuance of insurance. In addition, the Court has already found that the Surcharges do not merely "regulate insurance." As a result, the Surcharges do not satisfy

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[15] In support of its claim that the Surcharges do not have a risk-spreading effect, Travelers relies on *Group Life and Health Ins. Co. v. Royal Drug Co., Inc.*, 99 S.Ct. 1067 (1979), which involved an arrangement under which Blue Shield participants would pay only $2 for prescriptions purchased at "participating pharmacies." The Supreme Court held that the agreements between Blue Shield and the participating pharmacies did not spread any risk because those agreements merely reduced Blue Shield's costs for fulfilling an obligation which Blue Shield had already assumed. 99 S.Ct. at 1074.

Travelers argues that the Surcharges are similar to the agreements at issue in *Group Life* because they merely increase the costs for certain insurers, but do not affect whether those insurers will assume particular risks. (*See, e.g.*, Traveler's Reply Brief at 10-12). While this may be true, the agreements at issue in *Group Life* do not appear to have had the indirect risk-spreading effect already discussed. Accordingly, *Group Life* is distinguishable from this case.

the third McCarran-Ferguson factor, and are not saved from preemption by the savings clause.[18]

3. *Laches*

Intervenor HANYS argues that plaintiffs' challenge to the 13% Surcharge is barred by the doctrine of laches. It is undisputed that New York's hospital-rate setting statute has included a differential between various payors since the early 80's. Despite this long-standing policy, plaintiffs did not contest the differential portion of the statute until the enactment of the 1992 Act and the additional surcharges. Accordingly, HANYS asserts that plaintiffs' current challenge to the 13% Surcharge is untimely.

A claim will be barred by principles of laches if there is a showing of (1) a lack of diligence by the party against whom the defense is asserted; and (2) prejudice. *Costello v. United States*, 81 S.Ct. 534, 543 (1961). *See also Tunis v. Corning Glass Works*, 698 F. Supp. 452, 454 (S.D.N.Y. 1988) (laches requires showing of "unreasonabl[e] and inexcusabl[e] delay" and " 'substantial' prejudice"). Because the Court does not find that either of these requirements has been satisfied, the doctrine of laches does not preclude plaintiffs' claims with regard to the 13% Surcharge.

HANYS argues that plaintiffs have no excuse for not challenging the 13% Surcharge earlier, particularly since plaintiffs

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[18] Defendants argue that the 11% Surcharge is "intimately associated with the business of insurance" because "only payments made by commercial insurers are subject to the 11% differential." (Defendants' Reply Brief at 11). In making this argument, defendants imply that the 11% Surcharge is assessed directly against commercial insurers — and involves no other parties. To the contrary, it is undisputed that the 11% Surcharge is imposed on the hospital bill for patients covered by commercial insurers. As a result, even if commercial insurers are forced to pay the Surcharge, the collection of that Surcharge necessarily involves other parties.

More importantly, the Surcharge is not intended to impact "the business of insurance" or the relationship between an insurance company and its insured. Rather, the Surcharge is simply designed to reduce the attractiveness of particular forms of medical coverage, in order to make the Blues more competitive.

"generally supported the concept of a differential." (HANYS Brief 27). Plaintiffs strenuously disagree, and contend that they worked actively within the legislative process to have the differential eliminated. (HIAA Reply Brief at 33).

Without resolving the parties' dispute as to plaintiffs' prior position with regard to the 13% Surcharge, the Court finds that plaintiffs' delay in bringing this action was not unreasonable. New York first enacted the type of statutory hospital reimbursement scheme at issue here in 1983. (Defendants' Brief at 4). That scheme was challenged almost immediately, and one year later, in *Rebaldo*, the Second Circuit held that the statute was not preempted under ERISA. Given that ruling, it was not illogical for plaintiffs to refrain from expending their resources on what would likely be a unsuccessful legal action, and to work within the legislative process instead. Now that *Rebaldo* has, in this Court's view, been undermined by Supreme Court decisions interpreting ERISA's preemption clause, a legal challenge to the Surcharges has obviously become more viable.

The Court also does not find sufficient prejudice to either New York hospitals or the Blues to preclude this action. The Court assumes that hospitals and the Blues have, to a certain extent, relied upon the existence of the 13% Surcharge in making financial decisions. However, the harm that those parties will suffer if plaintiffs succeed here results more from an injunction against the 13% Surcharge rather than plaintiffs' alleged delay in bringing the action. *See Prudential Lines, Inc. v. Exxon Corp.*, 704 F.2d 59, 65 (1983) (considering prejudice "resulting from the delay").

Since at least 1983, New York's hospital rate-setting statute has not only been continuously modified, it has been substantially amended at least once. (*See* Defendants Brief at 3-9) (describing history of statute). During that amendment, the "differential" was changed from a 15% discount for the Blues, to the current 13% Surcharge. (*Id.* at 4-5). Thus, while the Blues and hospitals may have considered the existence of a differential for financial planning purposes, given the nature of the statute at issue, they could not have relied upon the exact level

of differential or surcharge, and had to have been prepared for further legislative amendments. Accordingly, the Court does not find that the delay between the Supreme Court's most recent rulings on ERISA preemption and the filing of this action has substantially prejudiced any party.

4. *The Federal Employee Health Benefit Act*

Defendants have cross-moved for summary judgment on plaintiffs' claims that the 11% and 13% Surcharges are preempted by FEHBA, the statute which governs health benefits for federal employees, claiming that FEHBA only applies to "premium taxes" or taxes on insurance companies measured by premiums. On August 25, 1992, the Office of Personnel Management ("OPM"), the administrative agency which administers the FEHBA program, notified defendants that, in its view, the Surcharges are preempted.[17] (Defendants' Brief at 48 n.40). The United States has filed an *amicus* brief in support of OPM's position. (Amicus Brief at 6).

Federal employees are eligible for health benefits through the FEHBA program, and can select coverage from any one of the participating insurance carriers in their region. 5 U.S.C. § 8905. "Contributions" or premiums under the program are assessed against the government and the individual employee, and are then deposited into the Employees Health Benefits Fund (the "Fund"). The FEHBA program is structured so that carriers pay care providers directly for covered treatment, and then are reimbursed by the Fund. 5 U.S.C. § 8909.

FEHBA's preemption provision states that:

> (c) EXEMPTION FROM STATE PREMIUM TAXES, — Section 8909 of title 5, United States Code, is amended by adding at the end the following:

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[17] The OPM has indicated that it also considers the 9% Surcharge to be preempted by FEHBA. (Holt Aff. Exs. C and D). Here, however, only plaintiff Mutual of Omaha ("Mutual") challenges the Surcharges under FEHBA, and Mutual has only raised the issue as to the 11% and 13% Surcharges. Thus, the Court need not consider the 9% Surcharge in this context.

(f)(1) No tax, fee, or other monetary payment may be imposed, directly or indirectly, on a carrier or an underwriting or plan administration subcontractor of an approved health benefits plan by any State, the District of Columbia, or the Commonwealth of Puerto Rico, or by any political subdivision or another governmental authority thereof, with respect to any payment made from the Fund.

(2) Paragraph (1) shall not be construed to exempt any carrier or underwriting or plan administration subcontractor of an approved health benefits plan from the imposition, payment, or collection of a tax, fee, or other monetary payment on the net income or profit accruing to or realized by such carrier or underwriting or plan administration subcontractor from business conducted under this chapter, if that tax, fee, or payment is applicable to a broad range of business activity.

[Pub. L. No. 101-508].

Defendants argue that the language of the statute as well as its legislative history are unambiguous, and reflect Congress' clear intent that FEHBA preemption apply only to state premium taxes. (Defendants' Brief at 44-45; Blues' Reply Brief at 11). It is well-established that if Congress' intent with regard to a particular issue is clear, "that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress." *Chevron*, 104 S.Ct. at 2781. if, however, Congress' intent is not clear, district courts should defer to an implementing agency's interpretation of a federal statute, as long as that interpretation is reasonable. *Id.* at 2782. *See also Presley v. Etowah County Commission*, 112 S.Ct. 820, 831 (1992) (same).

Contrary to defendants' arguments, the FEHBA statute itself does not clearly refer to state premium taxes. In fact, other than the heading to the amendment, the provision does not use the term "premium tax," but refers only to a "tax, fee, or other

monetary payment" imposed "directly or indirectly" on "any payment made from the Fund." This conflict between the amendment heading and the statutory language alone suggests that Congress' intent is less than clear.

The statute's legislative history is similarly ambiguous. (*See* Amicus Brief at 14) (referring to "sparse" legislative history for preemption provision). Even assuming that Congress intended FEHBA preemption to apply only to premium taxes, the legislative history does not resolve the question whether the 11% and 13% Surcharges qualify as premium taxes within the meaning of the statute.[18]

Because the Court finds that FEHBA's preemption provision and the statute's legislative history are both ambiguous, it will defer to OPM's reasonable interpretation of that clause. In order to be deemed reasonable, the agency's finding need not be "the only possible construction, or . . . the same finding the court would have made." *Lipscomb v. United States*, 906 F.2d 545, 548 (11th Cir. 1990). Rather, an agency's interpretation may be upheld if it is a "permissible construction of the statute." *Chevron*, 104 S.Ct. at 2782.

It is undisputed that the 11% and 13% Surcharges substantially increase the amount that FEHBA carriers must pay for hospital care rendered to their insureds. Because those carriers are then reimbursed for the payments by the Fund, the Surcharges also serve to increase, at least indirectly, "payments from the Fund." Given these circumstances — and absent any evidence to the contrary — the Court finds that OPM's determination that the Surcharges are preempted under § 8909(f) is a reasonable interpretation of the statute. Accordingly, the Court will defer to that interpretation and finds that the two Surcharges are both preempted under FEHBA as well as ERISA.[19]

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[18] The Committee Statements and Reports cited by defendants merely state that FEHBA carriers are exempt from "state premium taxes," but do not define that term.

[19] Defendants do not argue that the Surcharges fall within the exception to FEHBA's preemption clause, which exempts from preemption a "tax, fee, or payment . . . applicable to a broad range of business activity."

5. *The Actuarial Letter*

Finally, plaintiff Travelers challenges Actuarial Information Letter No. 6 (the "Actuarial Letter") issued by the New York State Department of Insurance. (Joseph Aff. Ex. 1). The Actuarial Letter imposes certain requirements on "stop-loss type policies," that is, insurance policies purchased by employee benefit plans to protect themselves against excess or catastrophic losses. Travelers claims that because the Actuarial Letter relates to employee benefit plans within the meaning of ERISA, that letter is also preempted. Defendants disagree, and argue that to the extent that the Actuarial Letter does relate to ERISA plans, it constitutes a regulation of insurance within the meaning of the savings clause.

Items 4 and 7 of the Actuarial Letter mandate the level of runoff reserves and the rate filings to be submitted for stop-loss policies. Because those provisions apply only to the insurance policy and/or insurer, and have no direct or indirect connection with employee benefit plans, they are not preempted by ERISA.

Item 6 provides that "[o]nly appropriate groups will be written, which excludes multiple-employer trusts and associations." Because that provision similarly regulates the insurer, not an ERISA plan, it is also not preempted under the statute.

The remaining items of the Actuarial Letter provide that:

1. The insurer must undertake to ensure that statutorily mandated benefits be covered under the employer's plan;

2. The insurer must agree to ensure that statutory conversion policies be provided, either by them or by another insurer;

3. Notice must be given to employees if and when the insurer becomes liable for runoff claims. We will accept a policy provision which requires the employer to pass along material provided by the insurer for such purposes;

• • •

5. The insurer must take full primary responsibility for the payment of all employer plan claims incurred but not yet paid at date of termination of the policy, unless one of two conditions occurs;

   a) The stop-loss plan is replaced by another stop-loss plan, issued by another carrier, which takes liability on a "paid" (as opposed to "incurred") basis; or

   b) If there is no replacement stop-loss plan, the insurer agrees to determine that the employer's plan has not been eliminated or materially reduced within 90 days (or three months) following termination of the stop-loss contract.

The Court finds that these items do have a connection with ERISA plans given that they attempt to mandate, through the stop-loss insurer, the benefits offered by and the administrative functioning of the ERISA plan purchasing the stop-loss coverage. Thus, those provisions will be preempted unless they fall within the savings clause.

As already noted, ERISA's savings clause exempts from preemption any state law which "regulates insurance." However, ERISA's deemer clause limits the scope of the savings clause, stating that "[n]either an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer . . . to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts . . ." 29 U.S.C. § 1144(b)(2)(B).

In interpreting the deemer clause, the Supreme Court has held that self-funded ERISA plans are not subject to state laws which otherwise "regulate insurance" within the meaning of the savings clause. *See FMC Corp.*, 111 S.Ct. at 409 ("the deemer clause . . . exempt[s] self-funded ERISA plans from state laws" regulating insurance). While an insured plan may be indirectly regulated through regulation of its insurer, "if the plan is uninsured, the state may not regulate it" at all. *Id.*, at 411. *See also*

Metropolitan Life, 105 S.Ct. at 2393 (noting that Court's interpretation of ERISA savings clause leaves insured plans open to indirect regulation through state insurance laws).

It is undisputed that the plan on whose behalf Travelers challenges the Actuarial Letter is self-funded, other than its purchase of stop-loss coverage from Travelers. The question then becomes whether the purchase transforms an otherwise uninsured plan into an insured plan for purposes of ERISA preemption.

Defendants correctly argue that nothing in ERISA "*compels* the conclusion that a plan that purchases excess risk coverage should not be treated as an insured plan." (Defendants' Brief at 42) (emphasis added). It does not appear that the Second Circuit has ruled on this issue. A number of other courts have, however, and have found that, for ERISA purposes, a plan "remains self-funded even with the stop-loss insurance." *Thompson v. Talquin Building Products Co.*, 928 F.2d 649, 653 (4th Cir. 1991). *Accord United Food & Commercial Workers & Employers Arizona Health & Welfare Trust v. Pacyga*, 801 F.2d 1157, 1161-62 (9th Cir. 1986) (because no insurance is provided directly to plan participants, plan should not be considered "insured").

The Court agrees. Accordingly, Items 1, 2, 3, and 5 of the Actuarial Letter are preempted by ERISA.[20]

For the foregoing reasons, plaintiffs' motions for summary judgment are granted in part and denied in part, and defendants' cross-motions are denied. Because the Court finds that the three Surcharges are all preempted by ERISA, defendants are

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[20] Defendants further argue that even if the plan at issue is considered self-insured despite its purchase of stop-loss coverage, the Court should not accept Travelers' interpretation of the deemer clause, because that interpretation "would result in the preemption of state insurance laws which have only a tangential effect on ERISA plans." (Defendants' Brief at 43). While defendants may disagree with such a broad reading of ERISA's preemption provision, that is the Supreme Court's interpretation of the clause, which is obviously binding on this Court.

enjoined from enforcing those surcharges against any commercial insurers or HMOs in connection with their coverage of any ERISA plans. Because the Court also finds that both the 11% and 13% Surcharges are preempted by FEHBA, defendants are enjoined from enforcing those surcharges against any insurers participating in the FEHBA program. Finally, because the Court finds that Items 1, 2, 3 and 5 of the Actuarial Letter are also preempted under ERISA, defendants are enjoined from enforcing those provisions of the Letter against any commercial insurers providing stop-loss coverage to self-funded ERISA plans.

SO ORDERED.

New York, New York
February 3, 1993

/s/Louis Freeh

LOUIS J. FREEH, U.S.D.J.

United States Court of Appeals

FOR THE

SECOND CIRCUIT

At a stated Term of the United States Court of Appeals for the Second Circuit, held at the United States Courthouse in the City of New York, on the 12th day of January, one thousand nine hundred and ninety-four.

Present: HON. J. EDWARD LUMBARD,
HON. RICHARD J. CARDAMONE,
HON. JOSEPH M. MCLAUGHLIN,
Circuit Judges.

Filed JAN 12 1994

THE TRAVELERS INSURANCE COMPANY,

Plaintiff-Appellee-Cross-Appellant,

Docket Nos.

HEALTH INSURANCE ASSOCIATION OF AMERICA, AMERICAN COUNCIL OF LIFE INSURANCE, LIFE INSURANCE COUNCIL OF NEW YORK, INC., AETNA LIFE INSURANCE CO., AETNA HEALTH PLANS OF NEW YORK, INC., MUTUAL OF OMAHA INSURANCE COMPANY, THE UNION LABOR LIFE INSURANCE COMPANY, PROFESSIONAL INSURANCE AGENTS OF NEW YORK, INC. TRUST,

93-7132L
93-7134CON
93-7148CON
93-7194XAP

Plaintiffs-Appellees,

NEW YORK STATE HEALTH MAINTENANCE ORGANIZATION CONFERENCE AND HEALTH SERVICES MEDICAL CORPORATION, MVP HEALTH PLAN, WELLCARE OF NEW YORK, MID-HUDSON HEALTH PLAN, OXFORD HEALTH PLAN, CAPITAL DISTRICT PHYSICIANS HEALTH PLAN, CHOICECARE LONG ISLAND, INDEPENDENT HEALTH, TRAVELERS OF NEW YORK, PHYSICIANS HEALTH SERVICES, PREFERRED CARE and U.S. HEALTHCARE,

Plaintiffs-Intervenor-Appellees,

- v. -

MARIO M. CUOMO, in his official capacity as Governor of the State of New York, MARK CHASSIN, M.D., in his official capacity as Commissioner of Health for the State of New York, SALVATORE R. CURIALE, in his official capacity as Superintendent of Insurance of the State of New York, MARY JO BANE, in her official capacity as Commissioner of Social Services of the State of New York, ROBERT ABRAMS, in his official capacity as Attorney General of the State of New York,

Defendants-Appellants-Cross-Appellees,

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, EMPIRE BLUE CROSS AND BLUE SHIELD, HOSPITAL ASSOCIATION OF NEW YORK STATE,

Intervenors-Defendants-Appellants-Cross-Appellees.

Petitions for hearing containing a suggestion that the action be heard in banc having been filed herein by Intervenors-Defendants-Appellants-Cross-Appellees The New York State Conference of Blue Cross and Blue Shield Plans and Empire Blue Cross and Blue Shield, by Intervenor-Defendant-Appellant-Cross-Appellee Hospital Association of New York State, and a petition for rehearing having been filed by State Defendants-Appellants-Cross-Appellees,

Upon consideration by the panel that decided the appeal, it is

Ordered that said petitions for rehearing are GRANTED.

No additional briefing or oral argument is required. The panel will file an amended opinion forthwith.

FOR THE COURT,

/s/George Lange III
GEORGE LANGE III, Clerk

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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The Travelers Insurance Company,

Plaintiff,

New York State Health Maintenance Organization Conference,

Intervenor,

-against-

Mario M. Cuomo, in his Official Capacity as Governor of the State of New York, et al.,

Defendants,

New York State Conference of Blue Cross and Blue Shield Plans, Empire Blue Cross and Blue Shield, and Hospital Association of New York State,

Intervenors.

92 Civ. 3999 (LJF)
Opinion and Order

----------X

The Health Insurance Association of America, et al.,

Plaintiffs,

New York State Health Maintenance Organization Conference,

Intervenor,

-against-

Mark Chassin, M.D. in his Official Capacity as Commissioner of Health of the State of New York, et al.,

Defendants,

New York State Conference of Blue Cross and Blue Shield Plans, Empire Blue Cross and Blue Shield, and Hospital Association of New York State,

Intervenors.

92 Civ. 5419 (LJF)
Opinion and Order

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LOUIS J. FREEH, U.S.D.J.

As stated in the Court's prior Orders, this case involves a challenge to three surcharges imposed by New York State on hospital rates charged to certain categories of payors.[1] On February 3, 1993, the Court granted plaintiffs' motion for summary judgment and enjoined defendants from enforcing the three surcharges on the grounds that they are preempted by the Employee Retirement Income Security Act of 1974 ("ERISA").[2] *See* 29 U.S.C. § 1144(a). Defendants and certain intervenors[3] now move pursuant to Fed. R. Civ. P. 62(c) to stay that ruling pending appeal. For the reasons stated below, the motion to stay is granted in part and denied in part. The Court's Order will be stayed as to the 13% Surcharge, but not as to the 9% and 11% Surcharges. Pending appeal, however, plaintiffs and any other parties subject to the 9% and 11% Surcharges are ordered to pay — or to continue paying — those funds into an interest-bearing escrow account.

DISCUSSION

The facts of this case were set out fully in the Court's February 3, 1993 Order and Opinion, and will not be restated here.

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[1] Section 2807-c(1)(b) of New York's Public Health Law provides that the hospital rate for inpatient services is increased by 13% for all patients covered by any form of health insurance other than Blue Cross and Blue Shield, a health maintenance organization ("HMO") or a government plan such as Medicare (the "13% Surcharge"). On April 2, 1992, the New York State Legislature adopted the Omnibus Revenue Act of 1992 (the "1992 Act"), which amends the Public Health Law to impose an additional 11% surcharge on rates charged to patients insured by commercial insurers (the "11% Surcharge"), and a 9% surcharge on the hospitalization costs for patients covered by HMOs (the "9% Surcharge").

[2] The Court also found that (1) the Tax Injunction Act does not preclude an injunction against the 9% and 11% Surcharges; (2) plaintiffs' claims as to the 13% Surcharge are not barred by the doctrine of laches; (3) both the 11% and 13% Surcharges are preempted by the Federal Employee Health Benefit Act; and (4) certain portions of a Department of Insurance interpretive letter are also preempted by ERISA.

[3] New York State Conference of Blue Cross and Blue Shield Plans, Empire Blue Cross and Blue Shield (collectively, "the Blues"), and Hospital Association of New York State ("HANYS").

In this Circuit, four factors must be considered in determining a motion for stay pending appeal: "(1) whether the movant will suffer irreparable injury absent a stay; (2) whether a party will suffer substantial injury if a stay is issued; (3) whether the movant has demonstrated 'a substantial possibility, although less than a likelihood, of success' on appeal, and (4) the public interests that may be affected."[4] *Hirschfeld v. Board of Elections*, 1993 WL 9699 at 3 (2d Cir. 1993) (*quoting Hayes v. City University of New York*, 503 F. Supp. 946, 963 (S.D.N.Y. 1980)) (other citations omitted). *See also Dubose v. Pierce*, 761 F.2d 913, 920 (2d Cir. 1985) (same).

No single factor is dispositive of the stay issue. Rather, a court must balance the equities presented in a particular case, and "explore the relative harms to [the] applicant and respondent, as well as the interests of the public at large." *Barnes v. E-Systems, Inc. Group Hospital Medical and Surgical Ins. Plan*, 112 S.Ct. 1, 3 (1991). *See also Hilton*, 107 S.Ct. at 2119 ([T]he traditional stay factors contemplate individualized judgments in each case . . .").

With regard to all three Surcharges, the Court finds that defendants do have a substantial possibility of succeeding on appeal. ERISA preemption, the central issue in the case, is a purely legal question, well-suited for resolution by an appellate court. Moreover, the law regarding ERISA preemption has been evolving over the last several years, resulting in several Supreme Court decisions. *See FMC Corp. v. Holliday*, 111 S.Ct. 403 (1990); *Ingersoll-Rand Co. v. McClendon*, 111 S.Ct. 478, 483 (1990). As a result, although the Court abides by the broad

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[4] Plaintiffs properly note that other courts have required "a strong showing" — not a mere "possibility" — of success on the merits. *See Hilton v. Braunskill*, 107 S.Ct. 2113, 2119 (1987); *United States v. Eastern Airlines, Inc.*, 923 F.2d 241, 244 (2d Cir. 1991); *767 Third Avenue Associates v. Permanent Mission of the Republic of Zaire*, 787 F. Supp. 389, 392 (S.D.N.Y. 1992). Given the Second Circuit's reiteration of the applicable rule less than one month ago, this Court is bound by the standard articulated in *Hirschfeld*. In any event, however, the same reasons which support the Court's finding that defendants have demonstrated a possibility of success on appeal also suggest that defendants may in fact be likely to succeed.

reading of ERISA's preemption clause expressed in its February 3, 1993 Order and Opinion, it recognizes that other courts might well disagree.

In addition, the Court's ruling was, to a large extent, based on its finding that the Second Circuit's decision in *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985), has been abrogated by later Supreme Court decisions.[5] Obviously, the Second Circuit may disagree, and may reaffirm its prior ruling.

Under the other factors relevant to a stay, however, the various Surcharges are distinguishable. With respect to the 13% Surcharge, the Court finds that defendants will suffer irreparable harm absent a stay. That Surcharge, which is paid directly to hospitals, has been in effect for approximately ten years. The hospitals, already in a precarious financial position, depend on those funds for their day-to-day operations. Thus, in the absence of some other, immediately available source of income, loss of the 13% Surcharge will cause a substantial and irreparable disruption in the functioning of and services provided by New York's hospitals.

On the other hand, plaintiffs, and the ERISA plans on whose behalf they are acting, will only suffer monetary damages if the Court's Order is stayed pending appeal. In the Court's view, the public interest in financially-stable hospitals and uninterrupted hospital services outweighs that monetary harm, and supports the imposition of a stay as to the 13% Surcharge.

The situation with respect to the 9% and 11% Surcharges is quite different. Those Surcharges, which were imposed by law in 1992, have never been collected by the State. Rather, plaintiffs and other parties subject to the 9% and 11% Surcharges have been paying the funds into escrow pending the

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[5] In *Rebaldo*, the Second Circuit found that New York's prior hospital rate-setting statute, which granted patients covered by Blue Cross a 12-15% discount on their hospital rates, was not preempted by ERISA.

outcome of this litigation. Thus, a stay of the Court's Order to permit collection of those Surcharges would alter, not maintain, the status quo between the parties.

More importantly, the Court does not find that defendants or any other party will suffer irreparable harm if its Order regarding the 9% and 11% Surcharges is not stayed. Although defendants claim that the Blues need the financial advantage created by the Surcharges in order to survive, defendants have not taken any action to enforce those Surcharges or to appeal this Court's grant of a preliminary injunction as to the 9% Surcharge. Accordingly, any claim of irreparable harm is undermined by defendants' own actions.

By contrast, plaintiffs have made a strong showing that they would suffer substantial harm if the Court were to stay its ruling. The 9% Surcharge is paid by HMOs directly to the State. Thus, as stated previously, even if a plaintiff were to succeed on the merits of its claims after it has already paid the Surcharge, it would be unable to recover those funds through an action in federal court and would be irreparably injured. *See United States v. New York*, 708 F.2d 92, 93-94 (2d Cir. 1983), *cert. denied*, 466 U.S. 936 (1984).

The 11% Surcharge is somewhat different in that it is paid by commercial insurers to hospitals, which then transfer the funds to the State. If, however, plaintiffs were to succeed on the merits of their claims, they would be required to sue each hospital individually in order to recover any money improperly paid — a substantial burden.

Finally, the Court does not find that the public interest favors a stay. While citizens of New York would generally benefit from the increase in state revenues resulting from the 9% and 11% Surcharges, participants in the ERISA plans which are the ultimate source of those funds will suffer corresponding harm. Under these circumstances, a stay would not be appropriate.

For the foregoing reasons, defendants' motion to stay the Court's February 3, 1993 Order pending appeal is granted in

part and denied in part. The Order will be stayed as to the 13% Surcharge, but not as to the 9% or 11% Surcharges. However, plaintiffs and any other parties subject to the 9% or 11% Surcharges shall pay those funds into an interest-bearing escrow account pending resolution of defendants' appeal.

SO ORDERED.

New York, New York
February 9, 1993

/s/Louis Freeh

LOUIS J. FREEH, U.S.D.J.

29 U.S.C. § 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

P.L. 101-508, § 7002(c), 104 Stat. 1388-330 (1990)

Exemption From State Premium Taxes - Section 8909 of title 5, United States Code, is amended by adding at the end the following:

(f)(l) No tax, fee, or other monetary payment may be imposed, directly or indirectly, on a carrier or an underwriting or plan administration subcontractor of an approved health benefits plan by any State, the District of Columbia, or the Commonwealth of Puerto Rico, or by any political subdivision or other governmental authority thereof, with respect to any payment made from the Fund.

New York Pub. Health Law § 2807-c(1)(a) to (c). General hospital inpatient reimbursement for the period commencing January first, nineteen hundred eighty-eight and ending December thirty-first, nineteen hundred ninety-three

1. Payor payments. Payments to general hospitals for inpatient hospital services provided to persons who are not eligible for payments as beneficiaries of title XVIII of the federal social security act (medicare) shall be determined pursuant to this section. Payor payments shall be as follows unless an alternative reimbursement methodology is authorized in accordance with paragraph (e), (f), (g), (h) or (i) of subdivision four of this section.

(a) Payments to general hospitals for reimbursement of inpatient hospital services provided to patients eligible for payments made by state governmental agencies; or provided in accordance with policies written by corporations organized and operating in accordance with article forty-three of the insurance law, or payment by such a corporation on behalf of subscribers of a foreign corporation as described in paragraph (d) of subdivision twelve of this section, which provide for reimbursement on an expense incurred basis; or provided to subscribers of organizations operating in accordance with the provisions of article forty-four of this chapter, shall be case based payments per discharge, for each diagnosis-related group established in accordance with paragraph (a) of subdivision three of this section, and shall include:

(i) a reimbursable inpatient operating cost component determined in accordance with subdivision five of this section;

(ii) capital related inpatient expenses determined in accordance with subdivision eight of this section;

(iii) a bad debt and charity care allowance determined in accordance with subdivision fourteen of this section, a primary health care services allowance determined in accordance with subdivision fourteen-b of this section and a bad debt and charity care allowance for financially distressed hospitals in accordance with subdivision fourteen-c of this section;

(iv) a projection of reimbursable inpatient operating costs to the rate year by the trend factor determined in accordance with subdivision ten of this section; and

(v) adjustments for any modifications to the case payments determined in accordance with paragraph (a), (b), (c) or (d) of subdivision four of this section.

(a-1) Payments made by local governmental agencies to general hospitals for reimbursement of inpatient hospital services provided to inmates of local correctional facilities as defined in subdivision sixteen of section two of the correction law shall be at the rates of payment determined pursuant to this section for state governmental agencies.

(b) Payments to general hospitals for reimbursement of inpatient hospital services provided to patients eligible for payments pursuant to the workers' compensation law, the volunteer firefighters' benefit law, the volunteer ambulance workers' benefit law or the comprehensive motor vehicle insurance reparations act; or enrolled in a self-insured fund which provides for reimbursement directly to general hospitals on an expense incurred basis, with the exception of those enrollees covered under a payment rate methodology agreement in accordance with the provisions of paragraph (a) of subdivision two of this section; or insured under a commercial insurer licensed to do business in this state and authorized to write accident and health insurance and whose policy provides inpatient hospital coverage on an expense incurred basis; or receiving inpatient hospital services pursuant to an out-of-plan benefits system authorized pursuant to section four thousand four hundred six of this chapter, except where such out-of-plan, inpatient hospital services are offered by an organization organized pursuant to the not-for-profit corporation law or which meets the qualifications of section 501(c) of the internal revenue code, shall be case based payments per discharge, for each diagnosis-related group established in accordance with paragraph (a) of subdivision three of this section, and equal to the case payments to general hospitals provided in accordance with paragraph (a) of this subdivision for services provided to subscribers of corporations organized and operating in accordance with article forty-three

of the insurance law, adjusted for uncovered services, and increased by thirteen percent and adjusted in accordance with paragraph (i) of subdivision eleven of this section. Without due cause general hospitals shall not refuse to accept direct payments from a payor who would otherwise be eligible to reimburse hospitals for inpatient services on a case based payment per discharge in accordance with this subdivision. A payor included in the payor categories specified in this paragraph or in paragraph (a) of this subdivision shall not be provided the option of payment to a general hospital for inpatient services based on the lower of hospital charges or the case based payment per discharge determined in accordance with this section for a patient or apportioning the appropriate case based payment per discharge for a patient by excluding payment for a preexisting condition or acquired condition which has to be treated along with the reason for the admission.

(c) Charge based payments. Payments to general hospitals for reimbursement of inpatient hospital services provided to those for whom a case based payment per discharge system is not authorized by paragraph (a) or (b) of this subdivision, or who are not covered under the provisions of paragraph (a) of subdivision two of this section, shall be on the basis of the hospital's charges; provided, however, for these patients the definition of a short stay patient pursuant to paragraph (d) of subdivision four of this section shall apply, and reimbursement to hospitals for such patients shall be at payments developed in accordance with paragraph (d) of subdivision four of this section, increased by thirteen percent. The maximum amount to be charged to any charge paying patient for a case shall be one hundred twenty percent of the case based payment per discharge as determined under paragraph (b) of this subdivision for the diagnosis-related group with which the patient is identified without adjustment in accordance with paragraph (i) of subdivision eleven of this section. Each general hospital shall establish a charge schedule and inpatient charges from this schedule shall be applied uniformly for all inpatient charge based payments made in accordance with this section.

1992 N.Y. Laws, ch. 55, § 348

Paragraph (i) of subdivision 11 of section 2807-c of the public health law is REPEALED and a new paragraph (i) is added to read as follows:

(i) For patients discharged during the period April first, nineteen hundred ninety-two through March thirty-first, nineteen hundred ninety-three insured under a commercial insurer licensed to do business in this state and authorized to write accident and health insurance and whose policy provides inpatient hospital coverage on an expense incurred basis, the payment rate shall be increased in addition to the payment rate conversion factor of thirteen percent by a supplementary payment rate conversion factor of eleven percent for a total conversion factor of twenty-four percent. . . .

1992 N.Y. Laws, ch. 55, § 349

Section 2807-c of the public health law is amended by adding a new subdivision 14-e to read as follows:

14-e. Supplementary payment rate conversion factor statewide pool. (a) Funds will be accumulated in a statewide pool created by the commissioner through the submissions by or on behalf of general hospitals of the component of rates of payment reflecting the supplementary payment rate conversion factor provided in accordance with paragraph (i) of subdivision eleven of this section.

(b) Funds accumulated in the supplementary payment rate conversion factor statewide pool, including income from invested funds, shall be deposited by the commissioner and credited to the general fund.

New York Pub. Health Law § 2807-c2-a(a) to (e)

2-a. (a) Notwithstanding any inconsistent provision of this section or any other law to the contrary, rates of payment to general hospitals for reimbursement of inpatient hospital services provided to subscribers of health maintenance organizations operating in accordance with the provisions of article forty-four of this chapter or article forty-three of the insurance law for patients discharged on or after July first, nineteen hundred ninety-two, excluding subscribers who are eligible for medical assistance pursuant to the social services law and participants in regional pilot projects established pursuant to chapter seven hundred three of the laws of nineteen hundred eighty-eight, shall be the case based payments per discharge as determined in accordance with subdivision one of this section or the per diem rates of payment determined in accordance with subdivision four of this section or the rate negotiated and approved pursuant to paragraph (b) of subdivision two of this section, whichever is applicable, increased by a factor of nine percent, subject to an elimination of or a reduction in such factor pursuant to paragraph (b) of this subdivision. The commissioner shall advise each health maintenance organization on or before June first for the nineteen hundred ninety-two rate period and on or before December first for each annual period thereafter commencing on January first whether it qualifies for an elimination of or a reduction in the factor; provided, however, that a health maintenance organization may appeal on or before May first for an elimination of or a reduction in pursuant to paragraph (b) of this subdivision, to be effective July first, the factor established for the rate year.

(b)(i) The increase shall be eliminated for a health maintenance organization if on or before May first for the nineteen hundred ninety-two rate period and on or before November first preceding the nineteen hundred ninety-three rate year and May first, if the health maintenance organization has appealed therefor, for the six month period thereafter commencing

on July first the health maintenance organization is determined by the commissioner of social services to be a managed care provider under section three hundred sixty-four-j of the social services law in each social services district within its service area, and to have enrolled at least ninety percent of the sum of its target numbers of medical assistance eligibles who are not exempt from participating in the managed care program and are residing in social services districts in its service area.

(ii) The nine percent increase shall be reduced according to the following schedule if, on or before the dates specified in subparagraph (i) of this paragraph: twenty-five percent if the health maintenance organization has enrolled twenty-five percent of its total target enrollment; fifty percent if the health maintenance organization has enrolled fifty percent of its total target enrollment; and seventy-five percent if the health maintenance organization has enrolled seventy-five percent of its total target enrollment. For the purposes of this subparagraph, the total target enrollment shall be calculated as specified in subparagraph (iii) of this paragraph.

(iii) A health maintenance organization may apply to the state commissioner of social services on or before May first for the nineteen hundred ninety-two rate period and on or before October first preceding the nineteen hundred ninety-three rate year for an exemption from participation in managed care programs in a social services district on such bases as demonstration of a good faith effort to enter into a managed care contract with the social services district, or such other criteria as the commissioner of social services may establish.

For purposes of this paragraph, a good faith effort shall include but not be limited to a determination by the commissioner that the health maintenance organization has fulfilled one of the following criteria; provided however that, these criteria shall only be applicable for the nineteen hundred ninety-two and nineteen hundred ninety-three rate years:

(A) The health maintenance organization has submitted an implementation plan to the district and would have begun enrollment in that district but for the failure or refusal of the district to sign a contract;

(B) The health maintenance organization has submitted a letter of intent to contract with each of the districts in its service area, and has executed contracts with half of the districts in its service area by July first, nineteen hundred ninety-two, and with two-thirds of the districts in its service by January first, nineteen hundred ninety-three, and would have been able to execute contracts in the remaining districts but for an agreement with the department of social services to delay implementation; or

(C) The health maintenance organization has submitted a letter of intent to contract with each of the districts in its service area, and has executed contracts with districts in which at least half of the non-exempt medicaid eligible population within the health maintenance organization's service area reside for the period beginning July first, nineteen hundred ninety-two, and with districts in which two-thirds of the non-exempt medicaid eligible population reside for the period beginning January first, nineteen hundred ninety-three, and would have been able to execute contracts in the remaining districts but for an agreement with the department of social services to delay implementation; or

(D) The health maintenance organization has enrolled a number of medical assistance eligibles sufficient to meet its total enrollment target for its otherwise non-exempt districts, even though the health maintenance organization does not yet have contracts in all such districts. In determining whether the health maintenance organization has met the total enrollment target for such districts for the years nineteen hundred ninety-two—nineteen hundred ninety-three, the commissioner shall include the health maintenance organization's medical assistance fee for service enrollment, which is defined as the annual fee for

service medical assistance visits made to a facility licensed pursuant to this article as a diagnostic and treatment center, which is operated either by the health maintenance organization or by a distinct not-for-profit corporation licensed under this article which provides or arranges for a majority of the health services to the health maintenance organization, divided by the annual average number of visits which commercial subscribers of the health maintenance organization make to such facilities. The commissioner of social services in making such a determination also shall consider whether the health maintenance organization is proceeding with implementation of a plan for the capitation of a substantial percentage of its medical assistance fee for service enrollment, as defined herein. Such plan shall include adherence to a specified, viable implementation schedule approved by the commissioner of social services. Notwithstanding any provision of law to the contrary, demonstration of a good faith effort under this clause shall entitle the health maintenance organization only to a seventy-five percent reduction in the nine percent increase imposed by this section.

For purposes of this paragraph, the health maintenance organization's service area shall be deemed not to include a social services district in which the health maintenance organization is exempted by the state commissioner of social services from participating in managed care programs. If the health maintenance organization's service area includes two or more regions which are not geographically contiguous, the health maintenance organization shall be allowed to apply for a waiver, exemption or reduction of the factor based on its contracts and enrollment within the health maintenance organization's entire service area, or separately on an aggregate basis for each non-contiguous geographic regions included in its service area. The target number for a social services district shall be determined by calculating the ratio of the health maintenance organization's subscribers in the social services district, excluding subscribers who are eligible for medical assistance pursuant to the social services law, subscribers who are beneficiaries of title XVIII of the federal social security act (medicare) and participants in regional pilot projects established pursuant to chapter seven hundred three of the laws of nineteen hundred

eighty-eight, to the number of all health maintenance organization subscribers residing in the social services district, excluding subscribers who are eligible for medical assistance pursuant to the social services law, subscribers who are beneficiaries of title XVIII of the federal social security act (medicare) and participants in regional pilot projects established pursuant to chapter seven hundred three of the laws of nineteen hundred eighty-eight, and applying that ratio to the medicaid managed care enrollment objective. The medicaid managed care enrollment objective for each social services district shall be the greater of: the number of medical assistance eligibles residing in the social services district who are not exempt from participating in managed care programs determined by the commissioner of social services to be the enrollment goal under approved medicaid managed care plans as of July first in the year preceding the rate year as required by subdivision seven of section three hundred sixty-four-j of the social services law; or five percent of the medical assistance eligibles who are not exempt from participating in managed care programs who reside in social services districts in which the first full year of an approved medicaid managed care plan has not been completed; or the actual number of medical assistance eligibles residing in the social services district who are not exempt from participating in managed care programs who are in fact enrolled in managed care programs excluding enrollment with managed care providers which are not health maintenance organizations or entities authorized to operate pursuant to section four thousand four hundred three-a of the public health law as of July first of the year preceding the rate year (except as of May first, nineteen hundred ninety-two for the rate period commencing July first, nineteen hundred ninety-two). The data used to determine the subscriber ratio shall be based on the most recent subscriber statistics available. For purposes of this paragraph, managed care program enrollees in a health maintenance organization shall be deemed to include persons eligible for medical assistance pursuant to the social services law enrolled by the health maintenance organization through an affiliation contract, approved by the commissioner in consultation with the commissioner of social services, with a prepaid health services plan.

(c)(i) Each health maintenance organization shall pay into a statewide health maintenance organization pool created by the commissioner the factor established pursuant to paragraph (a) of this subdivision, as adjusted in accordance with paragraph (b) of this subdivision, for each patient discharged in the previous calendar month commencing with patients discharged on or after July first, nineteen hundred ninety-two. Funds accumulated in the pool, including income from invested funds, shall be deposited by the commissioner and credited to the general fund.

(ii) Payments by health maintenance organizations to the pool shall be made on a time schedule established by the council, subject to the approval of the commissioner, by regulation; provided, however, that estimated payments shall be due on or before the fifteenth day following the end of each month unless payments of actual amounts due for such calendar months have been made within such fifteen day time period and provided further that no further payments will be required at such time as the commissioner, in consultation with the director of the division of the budget, determines that a total of thirty-one million dollars has been or will be collected for the fiscal year ending on March thirty-first, nineteen hundred ninety-three. Any amounts collected in excess of thirty-one million dollars for the fiscal year ending March thirty-first, nineteen hundred ninety-three shall be refunded to health maintenance organizations by the commissioner based on the ratio which health maintenance organizations' payments for such period bears to the total of the payments. Interest and penalties on arrearages shall be determined in accordance with subdivision twenty of this section in the same manner as interest and penalties on arrearages on payments to bad debt and charity care regional pools.

(iii) The commissioner is authorized to contract with a pool administrator designated in accordance with paragraph (c) of subdivision sixteen of this section, or if not available such other administrators as the commissioner shall designate, to receive and distribute health maintenance organization pool funds. In the event contracts are effectuated, the commissioner shall conduct or cause to be conducted annual audits of the receipt and

distribution of the pool funds. The reasonable costs and expenses of an administrator as approved by the commissioner, not to exceed for personnel services on an annual basis two hundred thousand dollars, shall be paid from the pooled funds.

(d)(i) Notwithstanding any inconsistent provision of this section or any other law to the contrary, for a corporation organized and operating in accordance with article forty-three of the insurance law that offers a point of service type benefit and in addition is certified on April first, nineteen hundred ninety-two to operate as a health maintenance organization for which the number of enrollees in the health maintenance organization is reduced on or after April first, nineteen hundred ninety-two by more than twenty percent based on transfers to point of service indemnity type benefits offered by such corporations, the subscriber ratio for purposes of determining the target number of medical assistance recipients calculated pursuant to paragraph (b) of this subdivision shall be based on subscriber ratio data for the period prior to April first, nineteen hundred ninety-two and the factor of nine percent established pursuant to paragraph (a) of this subdivision, as adjusted in accordance with paragraph (b) of this subdivision, shall be applied further to rates of payment to general hospitals for reimbursement of inpatient hospital services provided to enrollees in the point of service indemnity type benefit. If a corporation can provide the commissioner with satisfactory evidence that the transfers from the health maintenance organization to the point of service contracts were due to reasons or circumstances beyond the control of the corporation, this paragraph will not apply.

(ii) Each article forty-three insurance law corporation shall pay into the statewide health maintenance organization pool created pursuant to paragraph (c) of this subdivision the factor as applied to point of service indemnity type benefit reimbursement pursuant to subparagraph (i) of this paragraph in such time and manner as established pursuant to paragraph (c) of this subdivision for purposes of payments by health maintenance organizations.

(e) Health maintenance organizations operating in accordance with article forty-four of this chapter or article forty-three of the insurance law and corporations organized and operating in

accordance with article forty-three of the insurance law shall provide to the commissioner such information as the commissioner may require to effectuate the provisions of this subdivision, including by May first of each year data by county of total enrollment and separately identifying subscribers who are eligible for medical assistance pursuant to the social services law, subscribers who are beneficiaries of title XVIII of the federal social security act (medicare) and participants in regional pilot projects established pursuant to chapter seven hundred three of the laws of nineteen hundred eighty-eight, reflecting enrollment no earlier than the prior year.